

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940



CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE
DEPARTMENT OF Health BUREAU OF Vital
Records CREATED DURING THE NORMAL COURSE OF BUSINESS
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR
ON JUNE 4, 1954.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

Record Identification

1. TITLE:

Certificate of Death

2. Form No. if available

3. Type—(cards, paper, etc.)

Bound Book

4. Dates

5. Volume accumulated yearly

6. Size of Record

Misc.

7. Number of copies made

One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. Establish retention period for
records which are accumu-
lating daily

B. Dispose of present accumu-
lation, no additional accumu-
lation anticipated.

C. Microfilm and destroy orig-
inals

D. Microfilm and retain origi-
nals for length of time in-
dicated below

9. Recommended Retention Period

a. In Dept.

12 yrs.

b. In Storage Center

Micro. Perm.

c. Total

12 yrs.

and

Micro. Perm.

10. Equipment and space freed

11. In your opinion does this record have any historical significance?

YES ☐NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes. Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

Robert E. Fairley, M.D.
Commissioner of Health

3/28/63

Recommendation of Records Management Officer

14. Disposal Method

13. Recommended Retention Period

a. In Dept.

12 yrs.

b. In Storage Center

Microfilm
Permanent

c. Total

12 yrs.

and

Microfilm
Permanent

A. To be
sold as
scrap or
waste paper

B. To be
burned or
shredded

C. Historical, (to be transferred
to Dept. of Legislative
Reference.)

REMARKS:

C. J. Force
Records Management Officer

3/29/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G 06701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06701

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 624 N. Biddle Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 624 N. Biddle Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Robert Williams

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro6 (a) Single, married, widowed, or
divorcedWidowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

- 1873

8. AGE:

Years

Months

Days

If less than one day

70

hr.

min.

9. Birthplace

Charles Co. Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Benjamin Williams

13. Birthplace

Charles Co. Md.

14. Maiden Name

Sarah Ann

15. Birthplace

Charles Co. Md.

16 (a) Informant

Dorothy Collett

(b) Address

610 N. Gilmore St.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof July 28-43

(month, day, year)

(c) Cemetery or crematory

New Cathedral Cem.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

Address

91. So. Howard St.

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-24-1943 at 3:20 P.M.21. I certify that I took charge of the remains described above, held an
Autopsy & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐, accident ☐, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cordis - Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature Howard J. Almeida M.D.

Medical Examiner.

Date signed 7-25-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06702 937 G 06702

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **8 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **15 yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County **Baltimore**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **752 W. Franklin Street**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME **DAVE BOULER**

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No.

4. Sex
Male

5. Color or race
Col.

6 (a) Single, married, widowed, or divorced.
Single

6 (b) Name of husband or wife **None**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **July 1, 1900**

8. AGE: Years Months Days If less than one day
43 0 22 hr. min.

9. Birthplace **Winnsboro, South Carolina**
(Town, county, and state)

10. Usual Occupation **Stevedore**

11. Industry or business

12. Name **Sambo Boulter**

13. Birthplace **Winnsboro, S. C.**

14. Maiden Name **Judy ?**

15. Birthplace **Winnsboro, S.C.**

16 (a) Informant **Records, U.S. Marine Hosp.**

(b) Address **Baltimore, Md.**

17 (a) **Shipped** (b) Date thereof **July 27-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Winnsboro S. C.**
Location

18 (a) Funeral director **Mrs. Kate R. Williams**

(b) Address **3229 S. Salisbury St.**

19 **JUL 27 1943** (b) **Huntington Williams** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 23, 1943** at **11:30 AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **July 15, 1943** to **July 23, 1943** and that I last saw him alive on **July 23, 1943**.

Immediate cause of death

Hypertensive Cardiovascular disease with asystolia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operation:

of autopsy: **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

Signature

Address **Baltimore, Md.**

Date signed **7/24/43**

Duration
Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

06703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 06703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **626 S. Lakewood Avenue**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **60 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **626 S. Lakewood Avenue**

(If rural give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

3 (a) FULL NAME

SAVERI KWOKA

3 (b) If veteran, name war

3 (c) Social Security Account

No. ***

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed6 (b) Name of husband or wife **Josephine**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Unknown**

8. AGE: Years

76

Months

Days

If less than one day

hr.

min.

9. Birthplace

Austria

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name **Kwoka**13. Birthplace **Austria**14. Maiden Name **Unknown**15. Birthplace **Austria**16 (a) Informant **Albert Kwoka**(b) Address **626 S. Lakewood Avenue**17 (a) **Burial** (b) Date thereof **7/28/43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **St. Stanislaus**Location **Mt. Carmel Road**18 (a) Funeral director **M. J. Sadonski & Sons**(b) Address **6 East...**19 (a) **JUL 27 1943** (b) **William Williams**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 25 1943** at **5:30 P.M.**21. I certify that death occurred on the date above stated, that I attended deceased from **June 1930** to **July 1943**, and that I last saw him alive on **July 23 1943**

Immediate cause of death:

Myocardial insufficiency Duration **3 days**Due to **Chronic Myocarditis** **6 yrs.**Due to **Chronic Arthritis** **14 yrs.**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **John V. Szymanski** M.D.Address **9802 Eastern** Date signed **7-26-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06704

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2717 E. Preston St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2717 E. Preston St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Benjamin R. Winslow

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Mary G. DeVaughn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1876

8. AGE: Years Months Days

7719

If less than one day

hr.1866
min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

draftsman

11. Industry or business

12. Name Charles13. Birthplace Jefferson City Mo.14. Maiden Name Susan Corby15. Birthplace Jefferson City Mo.16 (a) Informant Mary G. Winslow(b) Address 2717 E. Preston St.17 (a) Burial (b) Date thereof 7/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory LorraineLocation Windsor Mill Rd.18 (a) Funeral director Clarence F. Hoffmann(b) Address 1639 N. Broadway.19 (a) JUL 27 1943Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1943. at M21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1943. to July 25, 1943. and that I last saw him alive on July 25, 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Atherosclerosis

Due to

Splenic disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1823 N. Paul St. Date signed 7/27/43

Duration

1 day5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06705

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

General toxemia
probable dilated
Due to right heart

Due to left nephritis
myocarditis

Other Conditions

(Include pregnancies within 5 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06706

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2305 Lauretta Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) URGENT

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) JUL 27 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, July 25, 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1943, to July 24, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G 06707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4250 Shamrock Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4250 Shamrock Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Margaret J. Suwalaki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1872

8. AGE: Years 70 Months 8 Days 11 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name Charles E. Kramming

13. Birthplace Germany

14. Maiden Name Mary A. ?

15. Birthplace Md

16 (a) Informant Mrs Catherine Deckert

(b) Address

17 (a) Burial (b) Date thereof 7/29/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Parkville Md

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Theford Rd

19 (a)

JUL 27 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1943 at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1943 to July 25 1943, and that I last saw her alive on July 25 1943.

Immediate cause of death

Coronary Thrombosis

Due to Arteriosclerotic heart disease

Hypertensive Cardio-Vascular Disease

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: None

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. Allen Deckert

Address 1127 St Paul St

Date signed 7/27/43

Duration

5-10 min

PHYSICIAN

Underline the cause to which death should be charged statistically.

06708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06708

Registered No.

830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 501 E. Chase St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 501 E. Chase St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Gerard Norris O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color, or race Black

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877

8. AGE: Years 66 Months 5 Days 15 hr. min.

9. Birthplace Charles County Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mother M. Teresa O.S.P.

(b) Address 501 E. Chase St.

17 (a) Burial (b) Date thereof July 28, 1943 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery Location Fredrick Road

18 (a) Funeral director Mrs. R.G. Elliott & Daughters

(b) Address 1129 N. Caroline St.

JUL 27 1943

for William M.P.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1943 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1943 to July 26, 1943, and that I last saw him alive on July 25, 1943.

Immediate cause of death: Bronchitis / Pneumonia

Due to: Chronic Bronchitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: R

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. Chetani

Address 112 E. Calver St. Date signed July 26, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06709

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1942 to July 25 1943, and that I last saw her alive on July 24 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy, birth, or month of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06710
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address: *Walkers + Caton Aves.*
 (c) Hospital or institution: *St. Agnes Hospital 75*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *3 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Baltimore*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *621 Cole King Rd.*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

Charles Heimer

3 (b) If veteran, name war

3 (c) Social Security Account

No. *215-07-7464*

4. Sex

Male

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11-12-79

8. AGE: Years

Months

Days

If less than one day

*63**6**8**14*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

High Master

11. Industry or business

Union Shipyard

12. Name

Catherine P. Heimer

13. Birthplace

Md.

14. Maiden name

Elaine Schaffer

15. Birthplace

Md.

16 (a) Informant

Dr. Charles Heimer

16 (b) Address

621 Cole King Rd.

17 (a)

Funeral

17 (b) Date thereof

7-28-43

17 (c) Cemetery or crematory

Cathedral

17 (d) Location

Baltimore, Md.

18 (a) Funeral director

James J. Taylor

18 (b) Address

Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 26 1943, 11:00 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *7-23-43* to *7-26-43*, and that I last saw him alive on *7-26-43*

Immediate cause of death

*Bilateral atelectasis*Due to *Ascaris 7*Due to *Larynx*

Other Conditions

(Include present within 3 months of death)

Date of operation *July 23-24-43*Major findings of operations *Tracheostomy*Cause of death *Ascaris larynx*of autopsy: *Same*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature *Alfred Schaffer*Address *St. Agnes Hospital*Date signed *7-26-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 27 1943
Wm. H. Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06711

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1611 E Biddle
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Scott - Clarence

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213 072 415

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Albertin Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-07

8. AGE: Years 35 Months 11 Days 1 If less than one day hr. min.

9. Birthplace

VA
(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

12. Name ARMSTEAD SCOTT

13. Birthplace

VA

14. Maiden Name ELVIRA

15. Birthplace

VA

16 (a) Informant

Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (b) Date thereof 7-28-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Crew. Hq.

Location

VA

18 (a) Funeral director J. G. Kelton

Address 3 Crestman St.

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1943 at 10^{20P} M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943 to July 25 1943 and that I last saw him alive on July 25 1943.

Immediate cause of death

cardiovascular collapse

Due to

diabetic acidosis & coma

Due to

Other Conditions

Fever, infection, uric acid

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Abraham Genecin

Address Johns Hopkins Hospital Date signed 7-28-43 M. D.

ABRAHAM GENECIN, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The entry of information should be carefully supplied.

06712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 06712

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Walbert Apt. Charles & Lafayette**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) **17**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MD** (b) County **Balto**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **Charles & Lafayette Ave**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jessie J. Gaines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **F.** 5. Color or race **W.** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **George G. Gaines**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan. 20, 1883**

8. AGE: Years **58** Months **6** Days **7** If less than one day hr. min.

9. Birthplace **Valdosta, Ga.**
(Town, county, and state)

10. Usual Occupation **housewife**

11. Industry or business

12. Name **James Kirby**

13. Birthplace **Unknown**

14. Maiden Name **Jessie Woods**

15. Birthplace **Unknown**

16 (a) Informant **George G. Gaines**

(b) Address **Walbert Apts.**

17 (a) **Burial** (b) Date thereof **7 28 43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Oaklawn Cemetery**

Location **Baltimore, Maryland**

18 (a) Funeral director **LORING BYERS**

JUL 28 1943 **1005 Bk Heights Ave**

19 (a) (Date rec'd by registrar) **Huntington Williams, M.D.**

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH **7-26-43** 19 **43** at **8:45 AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **June 1938** to **7/26 1943**, and that I last saw her alive on **7/26 1943**.

Immediate cause of death

Coronary Thrombosis

Due to **Hypertension Cardiovascular**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **George G. Kirby**
Charles H. Black Date signed **7/28/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06713
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4300 Valley View Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 116

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County BONO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Valley View Ave.
(If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3. FULL NAME

- Alton J. Kennedy
(b) If veteran, name war (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced married

- 6 (b) Name of husband or wife Grace A. Holder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1904

8. AGE: Years 30 Months 1 Days 4 If less than one day hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

12. Name Harry Kennedy

13. Birthplace Baltimore

14. Maiden Name Lizzie Schisler

15. Birthplace Baltimore

- 16 (a) Informant Mrs. Grace A. Kennedy

- (b) Address 4300 Valley View Ave.

- 17 (a) Burial (b) Date thereof 7/27/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory BARKO 2
Location Taylor Ave.

- 18 (a) Funeral director John O. Mitchell & Sons, Inc.

- 19 (a) 29-1943 (b) 29-1943
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1943 to July 27 1943, and that I last saw him alive on July 26 1943.

- Immediate cause of death
Cardiac syncope

- Due to
Coronary Arteriosclerosis

- Due to

- Other Conditions

- (Include pregnancy within 3 months of death)

- Date of operation

- Major findings of operation:

- of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Lohrke Ewald M. D.
Address 2045 St. Paul St. Date signed

Duration
about
10 hours
about
1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 92E

1. PLACE OF DEATH:

a. Baltimore City, Maryland

b. Street address

c. Hospital or institution

d. Length of stay in hospital or inst. yrs. mos. or days

e. Length of stay in Baltimore yrs. mos. or days

3. FULL NAME

3. a. If veteran, name war

3. b. Social Security Account No.

4. Sex 5. Color or race 6. a. Single, married, widowed, or divorced

6. b. Name of husband or wife

6. c. If alive, give age years

7. Birth date of deceased mo. day, yr.

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. a. Informant

b. Address

17. a. b. Date thereof

(Burial, cremation, or removal) (month) (day) (year)

c. Cemetery or crematory

Location

18. a. Funeral director John J. Mitchell & Sons, Inc.

b. Address

19. 8/11/43 1943

(Date rec'd by registrar)

Huntington Williams, M.D. Registrar

2. USUAL RESIDENCE OF DECEASED:

a. State b. County

c. City or town

d. Street No.

e. Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1943 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1943 to July 24 1943 and that I last saw her alive on July 24 1943.

Immediate cause of death

Myocardial

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, or public place? While at work?

(e) Means of injury

23. Signature M. Conrad P. Fode

Address 2000 N. ... Date signed

Duration

3 months

PHYSICIAN

Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6715

1. PLACE OF DEATH:

a. Baltimore City, Maryland

b. Street address

c. Hospital or institution

d. Length of stay in hospital or inst. yrs., mos., or days

e. Length of stay in Baltimore yrs., mos., or days

3. FULL NAME

a. If veteran, name war

b. Social Security Account No.

4. Sex

5. Color or race

6. a. Single, married, widowed, or divorced

b. Name of husband or wife

6. c. If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. a. Informant

b. Address

17. a. Burial

Date thereof 7-28-43

c. Cemetery or crematory

Location

18. a. Funeral director

b. Address

19. a. Burial

Thurston

2. USUAL RESIDENCE OF DECEASED:

a. State

b. County

c. City or town

d. Street No.

e. Citizen of foreign country?

If yes, name country

Yes or No

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-28

1943 at 4:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-27, 1943, to 7-28, 1943, and that I last saw him alive on 7-28-1943

Immediate cause of death

Peripneumonic collapse

Duration

2 days

Due to

Strangulated Hernia

Due to

Other Conditions

arteriosclerotic Heart Disease

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

a. Accident, suicide, or homicide

b. Date of occurrence

at

M

c. Where did injury occur?

(City or town) (County) (State)

d. Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

e. Means of injury

23. Signature

Henry M. M. D.

Address

Snai Hosp

Date signed 7-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

480

Registered 10216

1. PLACE OF DEATH:

- a) Baltimore City, Maryland
b) Street address 4940 BOSTON AVE.
c) Hospital or institution:
d) Length of stay in hospital or inst. yrs. mos. or days
e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:

- a) State b) County
c) City or town Baltimore
d) Street No.
e) Citizen of foreign country? (Yes or No)
If yes, name country

3. FULL NAME

3. a) FULL NAME
3. b) If veteran, name war 3. c) Social Security Account No.

4. Sex 5. Color or race 6. a) Single, married, widowed, or divorced
b) If married, name of spouse

6. b) Name of husband or wife
6. c) If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. a) Informant

- b) Address

17. a) b) Date thereof

17. a) b) Date thereof

- c) Cemetery or crematory

- Location

18. a) Funeral director

- b) Address

19. JUL 28 1943

- Date of death

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1943

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1943 to 7/21 1943, and that I last saw her alive on 7/1 1943.

- Immediate cause of death

- Due to

- Due to

- Other Conditions

- Date of operation

- Major findings of operation:

- of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence

- (c) Where did injury occur?

- (d) Did injury occur about home, on farm, industrial place, in public place?

- (e) Means of injury

23. Signature

- Address

- Date signed

Duration

3

PHYSICIAN

Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 61

MJ-24547

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. 6 yrs., 1 mo. 4 days

(e) Length of stay in Baltimore 50 yrs.

3. FULL NAME Max Friedenberg

3. a. If veteran, name war

3. c. Social Security Account No.

4. Sex

5. Color or race

6. a. Single, married, widowed, or divorced

Male

White

Separated

6. b. Name of husband or wife Mary

6. c. If alive, give age years

7. Birth date of deceased mo., day, yr. ? 1883

8. AGE: Years Months Days If less than one day

60 ?

?

?

hr

min

9. Birthplace England

Town, county, and state

10. Usual Occupation Printer

11. Industry or business Unemployed

12. Name Phillip Friedenberg (D)

13. Birthplace Russia

14. Maiden Name Katie ?

15. Birthplace Russia ? (D)

16. a. Informant BALTIMORE CITY HOSPITALS

b. Address (RECORDS)

17. a. Burial b. Date thereof 7-28-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18. a. Funeral director

b. Address

JUL 28 1943

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2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(d) Street No. 5 Irving Pl.

(e) Citizen of foreign country? (f) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 27 1943 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 23 1937 to 7 27 1943, and that I last saw him alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6 16 1943

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed 7 27 43

Duration

2 days

?

0 45

PHYSICIAN

Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

6718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06718

Registered No.

1. PLACE OF DEATH:

- a) Baltimore City, Maryland
b) Street address 1009 Providence St.
c) Hospital or institution:

- d) Length of stay in hospital or inst. yrs., mos., or days
e) Length of stay in Baltimore yrs., mos., or days

3. a) FULL NAME

NETTIE BEVERLEY BOWEN

3. b) If veteran, name war 3. c) Social Security Account No.

4. Sex Female 5. Color or race Colored 6. Single, married, widowed, or divorced Separated

6. b) Name of husband or wife b. c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug. 31, '82

8. AGE: Years 60 Months Days If less than one day hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name George Beverley

13. Birthplace Va.

14. Maiden Name Charlotte Carr

15. Birthplace Md.

16. a) Informant Mrs. Daisy Phillips

- b) Address 1009 Providence St.

17. a) Burial 4 Date thereof 7-28-43

- (Burial, cremation, or reburial) (month, day, year)

- c) Cemetery or crematory Mt. Auburn Cem.

- Location Baltimore, Md.

18. a) Funeral director Mrs. Frances A. Hensley

- b) Address 578 N. Biddle St. Huntingtown, Md.

JUL 28 1943

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2. USUAL RESIDENCE OF DECEASED:

- a) State Md. b) County

- c) City or town Baltimore

- (If outside city or town limits, write RURAL and give town)

- d) Street No. 1009 Providence St.

- (If rural give location)

- e) Citizen of foreign country? Yes or No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, '43 19 at 12M.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 12, 1943 to July 25, 1943 and that I last saw her alive on July 25, 1943

- Immediate cause of death

Cerebral hemorrhage 2 weeks
Due to Hypertension

- Due to

- Other Conditions Myocarditis

- (Include pregnancy within 3 months of death)

- Date of operation

- Major findings of operation:

- of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- c) Where did injury occur? (City or town) (County) (State)

- d) Did injury occur about home, on farm, industrial place, in public place? While at work?

- (Specify type of place)

- e) Means of injury

23. Signature William H. Watts

- Address 5151 Arlington Date signed 7/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically

06719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06719

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Frederick Green Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 415 N. Fremont Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bunnie Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/1904

8. AGE: Years 39 Months 21 Days 21 hr. min.

9. Birthplace Columbia, S.C.
(Town, county, and state)10. Usual Occupation Lawyer11. Industry or business Queen Copper Works12. Name Fayette Boyd13. Birthplace S.C.14. Maiden Name Anna Thompson15. Birthplace S.C.16 (a) Informant Eunice Lockwood(b) Address 711 E. ...17 (a) Burial (b) Date thereof 7/29/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutus Cemetery
Location Md18 (a) Funeral director Adolphus Halstead(b) Address 918 Druid Hill Ave.19 (a) BUL 28-1943 (b) Huntington
(Date of registration) (City, county, and state)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-1943, at 3 A M21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis of heart
Severe Coronary Phlebitis
Due to venous

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 7-25-43 at 2:45 A M(b) Where did injury occur? 500 Block Arlington Ave(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No(d) Means of injury Sharp instrument23. Signature Howard J. Wolden M.D.Date signed 7-25-43 Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The Every item of information should be carefully supplied.

G 06720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06720
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland *Monument St.*
(b) Street address *835 Hollins St.*
(c) Hospital or institution: *Sinai Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *18*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *835 Hollins St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mertha O Garman

3 (b) If veteran, name war

3 (c) Social Security Account
No. *none*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 14, 1873

8. AGE:

Years

Months

Days

If less than one day

70

4

13

hr.

min.

9. Birthplace

Centerville, Md.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Robert F. Vane

13. Birthplace

Near Denton, Md.

14. Maiden Name

Isabel J. Hardwood

15. Birthplace

Centerville, Md.

16 (a) Informant

Mina O. Draper

(b) Address

835 Hollins St.

17 (a) *Burial*

(b) Date thereof *7/28/43*
(month) (day) (year)

(c) Cemetery or crematory

Greenlawn Cemetery

Location

Greenlawn, Md.

18 (a) Funeral director

Howard M. Blight Jr.

(b) Address

4914 Belin Road

19 (a)

(b) *JUL 28 1943*

VB 188

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1943 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *July 27 1943* to *July 27 1943*, and that I last saw him alive on *July 27 1943*.

Immediate cause of death

Cardiac Insufficiency

Due to

Cardiac Dilatation and Hypertrophy

Due to

Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: *Cardiac Dilatation & Hypertrophy*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *While at work?*

(Specify type of place)

(e) Means of injury

23. Signature

Robert H. Jacobs

Address *Sinai Hospital*

Date signed *7/27/43*

G 06721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06721

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~State~~ MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 413 Moore Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Phillip L. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-14-1908

8. AGE:

Years

Months

Days

If less than one day

15

6

13

hr.

1928 min.

9. Birthplace Brockton Co., Md.

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Thomas Roberts13. Birthplace Talbot Co., Md.

MOTHER

14. Maiden Name Blaiche Green15. Birthplace Somerset Co., Md.16 (a) Informant Thomas H. Roberts(b) Address 413 Moore Street17 (a) Buried (b) Date thereof 7 89 43

(month) (day) (year)

(c) Cemetery or place of interment

Location St. Auburn CymBaltimore Md18 (a) Funeral director William A. Jackson(b) Address 916 P. Street19 (a) JUL 28 1943

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27-1943 at 10:20 AM21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 7-26-43 at P. 10(b) Where did injury occur Jonis Fall - Clapham Road(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No(d) Means of injury Found drowned23. Signature Howard J. Meade M.D.

Medical Examiner

Date signed 7-27-43

G 06722-82552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06722
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 735 Forest St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Dennis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced. ?

6 (b) Name of husband or wife

?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June? 1886

8. AGE: Years Months Days

If less than one day

57

?

?

1

?

hr.

min.

9. Birthplace

Md

?

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

?

13. Birthplace

?

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial

(b) Date thereof

July 28, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Calvary Cemetery

Location

A. A. County Md

18 (a) Funeral director

Mrs. Robert A. Elliott & Son

(b) Address

1129 N. Caroline St.

19 (a)

(b)

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/21

1943, 8:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1943 to 7/21 1943.

and that I last saw him alive on 7/21 1943.

Immediate cause of death

Tuberculosis
Sepsis

Duration

10 d.
10 d.

Due to

Due to

Other Conditions

Sepsis; poss.

gastric malignancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur at home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(d) Means of injury

23. Signature

Address

J. Sargman
Balto. City Hosp.

Date signed

M. D.

7/29

Physicians: please write the causes of death clearly and legibly.

JUL 28 1943

06723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

06723

Registered No.

3013

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Greene + Redwood
 (c) Hospital or institution: Univ. Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County a.a.co
 (c) City or town Shubertown
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 4 ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Ernest S. Green

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-07-7275

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Virgie Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1910

8. AGE:

Years

Months

Days

If less than one day

33

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

George Green

13. Birthplace

md.

MOTHER

14. Maiden Name

Rachel Green

15. Birthplace

md.

16 (a) Informant

Virgie Green

16 (b) Address

4 ave. Shubertown

17 (a)

Buried

(b) Date thereof

July 29

(Burial, cremation, or removal)

(month) (day) (year)

17 (c) Cemetery or crematory

Forest Lawn

17 (d) Location

a.a.co md

18 (a) Funeral director

James A. Stays

18 (b) Address

142 W. 11th St

19 (a)

(Date rec'd by registrar)

(b)

Huntington

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 26 1943 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943 to July 26 1943 and that I last saw him alive on July 26 1943.

Immediate cause of death

Brain encephalopathy

Duration

Due to Lead poisoning
Chronic (syphilitic) meningitis
Cephalitis

Due to

Other Conditions Pyloric ulcer
Chronic Prostatitis
 (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

General debility

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

A. B. HaganAddress Univ. Hosp. Date signed 7/26

JUL 28 1943

Huntington

06724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06724

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 910 Grand Hill Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Wm. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1926

8. AGE:

Years

Months

Days

If less than one day

69

hr. min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Wm. Harrison

13. Birthplace

N.C.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Rena Gaddis Henderson

(b) Address

910 Grand Hill Ave

17 (a)

Burial

(b) Date thereof

July 30-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mount Calvary

Location

A. A. Co. Md

18 (a) Funeral director

James A. Hayes

(b) Address

142 W. 1st St

19 (a)

Date rec'd by registrar

(b)

Huntington, W. Va.

MEDICAL CERTIFICATION

KO

20. DATE OF DEATH July 26 1943 at 12 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Ruptured Varicose Vein

of left leg.

Other Conditions Chronic myocardial

degeneration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed July 26 1943

G 06725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06725
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2224 Essex Street

(c) Hospital or institution:

Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2224 Essex Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Ratajczak

3 (b) If veteran, name war

3 (c) Social Security Account

No. ---

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

Married

6 (b) Name of husband or wife Thomas Ratajczak

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May ? 1880

8. AGE: Years Months Days If less than one day

63

2

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John Jadosek

13. Birthplace Poland

14. Maiden Name Jadwiga ?

15. Birthplace Poland

16 (a) Informant Thomas Ratajczak

(b) Address 2224 Essex Street

17 (a) Burial (b) Date thereof 7-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore Md

18 (a) Funeral director George A. Weber

(b) Address 705 So Anni street

JUL 28 1943 (b) Huntington Williams

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1943 to July 27 1943 and that I last saw her alive on July 26 1943.

Immediate cause of death

Hemorrhage
Cerebral.

Due to

Acute Relation Heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James Graham Martin

M. D.

Address 516 Cathedral Date signed 7-27-43

Duration

several
days

Less

months

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06726

80317 YA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06726

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 612 N. Monroe St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Maude Ferklar

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Separated

6 (b) Name of husband or wife Roland LeRoy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1899

8. AGE: Years Months Days If less than one day
43 10 18 hr. min.9. Birthplace Maryland (Hagerstown)
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Thomas Feigley

13. Birthplace Pa.

MOTHER

14. Maiden Name Fanny Corbin

15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 7-28-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory
Location Balto., Md.

18 (a) Funeral director

(b) Address

19 (a) (b) JUL 28 1943

V8 154

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1943 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 7/23 1943 to 7/26 1943.
and that I last saw him alive on 7/26 1943Immediate cause of death Cerebral
embolus; gentle
cardiac failure
Due to Rheumatic
disease & fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Surman

Address Balto. City Hosp Date signed 7/26

Duration

2-3 hr

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

5727

JL - 82340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06727
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern Ave.

(b) Street address

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 226 E. Madison St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Samuel Kazazis

3 (b) If veteran, name war

3 (c) Social Security Account

No. Yes

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1878

8. AGE: Years Months Days If less than one day

64

8

22

hr.

min.

9. Birthplace Greece

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Tom Kazazis

13. Birthplace Greece

MOTHER

14. Maiden Name Mary Coliza

15. Birthplace Greece

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 27/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director John A. Miller

(b) Address 7304 Jefferson St.

JUL 28 1943 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25 1943 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1943 to 7-25 1943

and that I last saw him alive on 7-25 1943

Immediate cause of death

? Ca of Stroke

Due to

Due to

Other Conditions Ser. Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Donald Probst

Address Baltimore City Hosp Date signed 7-28-43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

436522

G 06728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH06728
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore

(a) State Md. (b) County Calverton

(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)(d) Street No. 2126 Lincoln Rd. Jones Cr.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Dorothy Brittain Brittain

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-14-18

8. AGE:

Years

Months

Days

If less than one day

25

4

12

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

George Isenrock

13. Birthplace

Md.

14. Maiden Name

Agnes Tracey

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Jul 29/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Parkwood

Location

Hawthorne

18 (a) Funeral directors

Geo. M. Friel, Jr.

(b) Address

811 N. W. Ave. St.

19 (a)

JUL 28 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1943 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 18, 1943 to July 26, 1943 and that I last saw him alive on July 26, 1943

Immediate cause of death

Respiratory Failure

Due to

Pulmonary
Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alexander Goncin

Address Johns Hopkins Hospital Date signed 7-26-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

06729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06729
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2803 Garrison Blvd.

(c) Hospital or institution:

Garrison Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County - - -

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 E. 37th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

NO

3 (a) FULL NAME

BERTHA E. SIMPKINS

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife John Thomas Simpkins

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Apr. 1. 1871

8. AGE:

Years

Months

Days

If less than one day

72

3

24

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Harry Fields

13. Birthplace Maryland

14. Maiden Name ?

Cooksey

15. Birthplace Maryland

16 (a) Informant Mrs. Howard S. Worthington

(b) Address Ambassador Apts.

17 (a) Burial (b) Date thereof Jul. 28, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore Md.

18 (a) HENRY SANDER & SONS, INC.

(b) Address

North Ave. & Broadway.

19 (a)

(b)

Huntington Williams, M.D.

Registrar

Jul 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1943 at 3:20 PM

21. I certify that death occurred on the date above stated, that I attended deceased from June 1, 1943 to July 20, 1943.

and that I last saw her alive July 20, 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06730
MJ-82866BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06730
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

3 (a) FULL NAME

John Fuka

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2-21-1883

8. AGE:

Years

Months

Days

If less than one day

60

5

5

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Balto. City Highway Dept.

11. Industry or business

FATHER

12. Name John Fuka

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary Trojacek

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a)

Burial

(b) Date thereof

7-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

JUL 28 1943

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2128 Cambridge St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1943 at 8:00 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/26 1943 to 7/26 1943
and that I last saw him alive on 7/26 1943

Immediate cause of death

Heat prostration
Cerebral edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Cerebral edema

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul M. D.

Address B.C.H.

Date signed 7/26/43

437948
G 06731BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06731
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2214 Greenmount Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Betty Lou Davidson

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.Female WhiteSingle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-43

8. AGE: Years Months Days If less than one day

2 17 wh. hr. min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

FATHER
MOTHER

12. Name

Robert Davidson

13. Birthplace

Pa

14. Maiden Name

Ethel ?

15. Birthplace

Pa

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

7/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Balto. Cem.

Location

18 (a) Funeral director

Mary M. Wiadefeld

(b) Address

501 E. 22 St.

JUL 28 1943

(b) Huntington Williams, M.D. Registrar

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1943 at 8:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1943 to July 27 1943 and that I last saw him alive on July 27 1943.

Immediate cause of death

Pneumonia

Duration

Due to

Due to

Other Conditions

Hydrocephalus

(Include pregnancy within 3 months of death)

Date of operation

7/17/43

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James KaysAddress James Kays, M.D. Date signed 7/27/43

438609

G 06732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06732

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EUGENIA MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-30-41

8. AGE:

Years

Months

Days

If less than one day

1

10

27

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edward MARTIN

13. Birthplace

Md

14. Maiden Name Josephine

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

7-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore County

Location

E. North

18 (a) Funeral director

Wm. E. Humphrey

(b) Address

1921 N. Broadway

19 (a)

(b) Hunterington Williams

JUL 28 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1400 N BROADWAY

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1943

at 7:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1943 to July 27 1943, and that I last saw her alive on July 27 1943.

Immediate cause of death

cerebral

failure

Duration

26 hr

Due to

Central

Due to

cerebral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

JUL 28 1943

correct age is especially important. In answer, please write the cause of death clearly and legibly.

G 06733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 24 1943, to July 26 1943, and that I last saw him alive on July 26 1943.

Immediate cause of death: Pneumonia
hypostatic pneumonia
chronic

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2151 Waltham Date signed 7/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G 06734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06734
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1229 E Lomvale St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *9-9*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

William J. Tilgis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

75 0 11 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) *JUL 28 1943*

(b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*(d) Street No. *1229 E Lomvale St*

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 26 1943* at *7:30* M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *May 1 1943* *July 26 1943*and that I last saw him alive on *July 26 1943*

Immediate cause of death

*Coronary occlusion*Due to *Hypertension cardio-**vascular disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

*William F. Richardson M.D.*Address *E. Biddle St*Date signed *7/27/43*

Duration

3 days

Due to

4 years

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, with correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06735

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

5 (a) Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

44 less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

(f) If rural, give location

(g) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, with correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 28 1943

Huntington Hillman

Address 2324 Reisterstown Rd. Date signed 7/27/43

G 06736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06736
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limit, with RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/28 1943, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1943, to 7/28 1943,

and that I last saw him alive on 19

Immediate cause of death cerebral vascular accident

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, with correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS

G 06737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06737
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 320 Pine Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 320 Pine St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Hortense Baker

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3/15/1911

8. AGE: Years

32

Months

4

Days

9

If less than one day

hr.

min.

9. Birthplace Jonesboro, N.C.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name John Baker13. Birthplace Reidsville, N.C.14. Maiden Name Elizabeth15. Birthplace Chatham County, N.C.16 (a) Informant Elizabeth Jessie (M)(b) Address 320 Pine St.17 (a) Burial (b) Date thereof 7/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. AuburnLocation Baltimore, Md18 (a) Funeral director Charles H. Cooper(b) Address 514 N. Calhoun St.

19 (a) (b)

(Date rec'd by registrar)

Registrar

William Williams JUL 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1943 9:PM M21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1943 July 24 1943 and that I last saw him alive on July 24 1943.

Immediate cause of death

Duration

Lobar Pneumonia 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. F. NoeAddress 601 N. Carroll St. Date signed 7/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

Physicians: please write the causes of death clearly and legibly.

06738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06738

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1643 Penna. Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1643 Penna. Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Kelly C. Pagan

3 (b) If veteran, name was

World War I

3 (c) Social Security Account

No. ✓

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Eleanor Pagan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1899

8. AGE: Years 43 Months 43 Days 10 26 hr. min.
Less than one day

9. Birthplace Gastonia, N.C.
(Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Eleanor Pagan

(b) Address 1643 Penna. Ave.

17 (a) Burial (b) Date thereof 7-30-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Int. Bakery
Location Brooklyn, Ind.

18 (a) Funeral director George T. D. Gibson, Jr.

(b) Address 1725 Laurel Hill Ave.

19 (a) JUL 28 1943

(Date rec'd by registrar) Huntington Williams, M.D. Address 4543 Penna. Ave. Date signed 7/27/43

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1943, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1943, to 7/26 1943, and that I last saw him alive on 7-26 1943.

Immediate cause of death

Myocardial Failure

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Franklin Phillips M.D.

G 06739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06739

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date read by registrar)

JUL 28 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1943 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1940 to July 27 1943, and that I last saw him alive on July 26 1943

Immediate cause of death

Coronary Thrombosis

Due to

Hypertension - Atherosclerosis

Due to

Chronic Pulmonary Nephritis

Other Conditions

Myocardial

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2878 Hartford Rd

Date signed

M. D.

7/27/43

G 06740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06740

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Lincoln Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William E. Todd

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 218-03-4130

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ada Todd

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1893

8. AGE: Years 50 Months 6 Days 25 hr. min.

9. Birthplace Balto. Md.

10. Usual Occupation Clerk Bethlehem

11. Industry or business Steel

12. Name Thomas E. Todd

13. Birthplace Balto. Md.

14. Maiden Name Ethel W. Walizer

15. Birthplace Balto. Md.

16 (a) Informant Ada Todd

(b) Address 1705 Patapsco Rd

17 (a) Burial (b) Date thereof July 30, 1943

(c) Cemetery or crematory Cedar Hill

Location A. A. B.

18 (a) Funeral director G. J. Howard & Sons

(b) Address 1400 N. B. Harbor

JUL 28 1943

Authenticated by Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt City

(c) City or town Baltimore

(d) Street No. 1705 Patapsco Rd

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/1943 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26/1943 to 7/27/1943, and that I last saw him alive on 7/27/1943.

Immediate cause of death

Uremia

Due to Renal insufficiency on nephrosclerotic basis

Due to Malignant Hypertension

Other Conditions Hypertension Cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Nephrosclerosis, hypertensive

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Walizer

Address Lincoln Hospital Date signed 7/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06741
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St

(c) Hospital or institution:

Home for Aged

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rose Kasilip

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife Thomas Kasilip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1862

8. AGE:

Years

Months

Days

If less than one day

81

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER

12. Name Joseph Smith

13. Birthplace W. S. A

MOTHER

14. Maiden Name Lena Drury

15. Birthplace W. S. A

16 (a) Informant Little Sister of the Poor

(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof July 29, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Reia Woodfield

(b) Address 914 Greenmount Ave

19 (a) 28 1943 (b) 11

VB 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1943 to July 27 1943 and that I last saw her alive on July 27 1943

Immediate cause of death: General
Toxemia secondary
impression of leucemia
Due to of liver

Duration

2 wks

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide none

(b) Date of occurrence none at M

(c) Where did injury occur? none

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? none

(Specify type of place)

(e) Means of injury

23. Signature Otto H. Dyer

Address 928 E. North Ave signed 7/27/43

435475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06742
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHN HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Melvin Slack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-31-43

8. AGE: Years

Months

Days

If less than one day

34

26

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Charles Slack

13. Birthplace

Md

14. Maiden Name

Catherine Schoene

15. Birthplace

Md

16 (a) Informant

(b) Address

JOHN HOPKINS HOSPITAL

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

7-29-43

(c) Cemetery or crematory

Lorraine Park

Location

Baltimore County

18 (a) Funeral director

George H. Schwab

(b) Address

2101 Lubbock Avenue

JUL 28 1943

Dr. Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Landsdowne

(If outside city or town limits, write RURAL and give town)

(d) Street No.

117 Ridge Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27

1943, at 520¹ M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1943 to July 27 1943, and that I last saw him alive on July 27 1943.

Immediate cause of death

Respiratory

obstruction?

Duration

2405

Due to

traumatic
table ??

Due to

Other Conditions

was

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

7-27-43

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Rene Kaye

Address

Johns Hopkins

Date signed

7/28

43

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06743

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 501 Hawthorn Road.(c) ~~Hospital or institution:~~(d) ~~Length of stay in hospital or inst. (yrs., mos., or days)~~(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Beth-

(If outside city or town limits, write RURAL and give town)

(d) Street No. 501 Hawthorn Road.

(If rural give location)

(e) If foreign born, how long in U. S. A.?

years

3. (a) FULL NAME

Charlotte Maye Hazard Cross.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed.6 (b) Name of husband or John Miller Cross.6 (c) ~~Married, give age~~ years7. Birth date of deceased (mo., day, yr.) Nov. 9 - 1847

8. AGE: Years

94

Months

8

Days

17

If less than one day

hr.

min.

9. Birthplace Newport, Rhode Island

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Rev. A. Hazard13. Birthplace Newport R. I.

MOTHER

14. Maiden Name Abbie S. Card15. Birthplace Newport - R. I. -16 (a) Informant H. C. Preston(b) Address 501 Hawthorn Road17 (a) Burial (b) Date thereof July 29 - 43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Oxford Pk.18 (a) Funeral director Henry W. Jenkins(b) Address McCulloch & Orchard19 (a) JUL 28 1943(b) Huntington Williams

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 W. 8 AM21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1943 to July 27 1943 and that I last saw deceased on July 26 1943Immediate cause of death Coronary
thrombosis with myocardial
infarction.Due to chronic arteriosclerosis
coron.

Due to

Other Conditions Brucellosis
infection

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. Delmas Bouché

M. D.

Address 24 E. Eager Date signed 7/28/43

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

06744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06744
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

(m) Address

(n) Address

(o) Address

(p) Address

(q) Address

(r) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country

If yes, name country

(f) If rural give location

(g) (Yes or No)

(h) (Yes or No)

(i) (Yes or No)

(j) (Yes or No)

(k) (Yes or No)

(l) (Yes or No)

(m) (Yes or No)

(n) (Yes or No)

(o) (Yes or No)

(p) (Yes or No)

(q) (Yes or No)

(r) (Yes or No)

(s) (Yes or No)

(t) (Yes or No)

(u) (Yes or No)

(v) (Yes or No)

(w) (Yes or No)

(x) (Yes or No)

(y) (Yes or No)

(z) (Yes or No)

(aa) (Yes or No)

(ab) (Yes or No)

(ac) (Yes or No)

(ad) (Yes or No)

(ae) (Yes or No)

(af) (Yes or No)

(ag) (Yes or No)

(ah) (Yes or No)

(ai) (Yes or No)

(aj) (Yes or No)

(ak) (Yes or No)

(al) (Yes or No)

(am) (Yes or No)

(an) (Yes or No)

(ao) (Yes or No)

(ap) (Yes or No)

(aq) (Yes or No)

(ar) (Yes or No)

(as) (Yes or No)

(at) (Yes or No)

(au) (Yes or No)

(av) (Yes or No)

(aw) (Yes or No)

(ax) (Yes or No)

(ay) (Yes or No)

(az) (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended

deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Incomplete entries may result in death being incorrectly recorded.

JUL 29 1943

VS 158

Registrar

06745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 06746

488430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06746

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1001 Wilmet Court
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Sarah Rabinowitz

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Raron

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

11-12-81

8. AGE:

Years

Months

Days

If less than one day

61816

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Rubin Tellman13. Birthplace Russia14. Maiden Name Anna ?15. Birthplace Russia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

7-29-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Mt Carmel

Location

German Hill Rd

18 (a) Funeral director

Fast Lane Inc

(b) Address

11439 E. Balt St

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943, at 10:15 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1943 to July 28 1943 and that I last saw her alive on July 28 1943.

Immediate cause of death

Septicemia - staphylococcusDue to Acute right parotitisDue to Coronary thrombosis, cardiac failure + general debility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Robert DayAddress Johns Hopkins HospitalDate signed 7/28/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

JUL 29 1943

G 06747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G 06747
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address Greene St.
 (c) Hospital or institution: University Hosp.
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 28
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Balt
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 4107 Mame Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME

Mrs. Rebecca Finkler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5 Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1873

8. AGE:

Years

Months

Days

If less than one day

70

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Harry

13. Birthplace

Russia

14. Maiden Name

15. Birthplace

Russia

16 (a) Informant

Hosp. Records

(b) Address

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

7-29-43

(month) (day) (year)

(c) Cemetery or crematory

Windsor Hill Rd.

Location

Same

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1439 E. Balt St.

19 (a) Informant

Thurston Williams, M.D.

(b) Address

Thurston Williams, M.D.

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1943 at 3:45 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1943 to 7-28 1943 and that I last saw him alive on 7-28 1943

Immediate cause of death

Cerebro-Vascular Accident

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thomas B. Williams

Address

Univ. Hosp.Date signed 7/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06748

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1180

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Amelia S. Pracht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1872

8. AGE: Years 90 Months 10 Days 22 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Charles Pracht

13. Birthplace Germany

14. Maiden Name Anna Mathes

15. Birthplace Germany

16 (a) Informant Helen Pracht

(b) Address 3707 Liberty Heights Ave.

17 (a) Burial (b) Date thereof 7/29/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons, Inc.

(b) Address 1906 Eutan Place

19 (a) 22 1943 (b) Registrar
(Date rec'd by registrar)

VS 184

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 - 1941 to July 27 1943, and that I last saw him alive on July 26 1943.

Immediate cause of death

Chronic Hypertension

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard H. Warner

Address 2604 Garrison Blvd. Date signed 7-28-43

Duration

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06749
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3116 Loch Raven Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3116 Loch Raven Rd.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W

6 (b) Name of husband or wife Alice E. Burgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1877

8. AGE: Years Months Days If less than one day

66

1

12

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Garage & Filling

11. Industry or business Station

FATHER
MOTHER

12. Name William H. Ellis

13. Birthplace Baltimore Md.

14. Maiden Name Catherine Schulner

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Myrtle Mitchell

(b) Address 3116 Loch Raven Rd.

17 (a) Burial (b) Date thereof 7/29/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

JUL 29 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 26 1943, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 1941 to July 26 - 1943, and that I last saw him alive on July 15 1943.

Immediate cause of death

Coronary thrombosis -

Due to

Coronary thrombosis (arteriosclerosis)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. Brooke Bayle

Address 5217 - Mayfield Rd

Date signed 7/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED, WITH CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

G 06750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06750

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home + Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Owings, Mrs Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frank S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 13-1879

8. AGE:

Years

Months

Days

If less than one day

64

6

15

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

James E Roberts

13. Birthplace

Baltimore Md.

14. Maiden Name

Josephine M. Kelley

15. Birthplace

Baltimore Md.

16 (a) Informant

Howard M. Owings

(b) Address

7307 Fair Ave

17 (a)

Burial

(b) Date thereof

July 2/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

East End North

Location

Baltimore County

18 (a) Funeral director

William B. Coe

(b) Address

12125 Paul St

19 (a)

JUL 29 1943

(Name of Registrar)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7307 Fair Ave

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 P 1943 at P A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1943 to July 24 1943, and that I last saw him alive on July 2 P 1943.

Immediate cause of death

Carcinoma of Head

of Pancreas

Due to with Metastases

to liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 27 1943

Major findings of operation:

as above

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

J M. Geller, Jr.

M. D.

Address Church Home + Hospital

Date signed 7-28-43

G 06751

BALTIMORE CITY HEALTH DEPARTMENT

G 06751

82812

YA

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 400 E. Chase St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John McCloskey

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1869

8. AGE: Years Months Days If less than one day

74

4

16

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bridge Builder

12. Name James

13. Birthplace Ireland

14. Maiden Name Margaret Owens

15. Birthplace Ireland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 7/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Balto.

Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 1243 St. Paul St

19 (a) JUL 29 1943 (b) Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1943, at 6:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1943, to 7/25 1943 and that I last saw him alive on 7/25 1943.

Immediate cause of death

Pneumonia
Cerebral thrombosis
Due to arteriosclerotic
C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sugman

Address Balto. City Hosp. Date signed 7/28

M.D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

06752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06752
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 824 McKean ave.
(c) Hospital or institution: -----(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---
(c) City or town Baltimore
(d) Street No. 824 McKean ave.
(e) Citizen of foreign country? NO (If rural, give location) (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN H. PRUSSING

3 (b) If veteran, name war
NO3 (c) Social Security Account
No. NO

4. Sex Male 5. Color or race white 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Bachmann Prussing
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1882

8. AGE: Years 61 Months 6 Days 4 hr. min.

9. Birthplace Baltimore, Md.

10. Usual Occupation Retired Carpenter

11. Industry or business

12. Name John H. Prussing
13. Birthplace Germany14. Maiden Name Caroline Kemmel
15. Birthplace Balto. Md.16 (a) Informant Mrs. Mary Bachmann Prussing
(b) Address 824 McKean ave.17 (a) Burial (b) Date thereof July 29/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel18 (a) Funeral director J. J. Evans Jones
(b) Address 118 N. Mt. Royal Ave.

19 JUL 29 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1943 to July 27, 1943.
that I last saw him alive on July 27, 1943.Immediate cause of death
Coronary atherosclerosisDue to C.P. Lvs. Lvs. +
Kidney
Emboli of heart.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address 804 N. Fulton St. Date signed July 28/43

Duration	Physician
1 hr	
2 mo	
2 yr	

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06753

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (year, month, or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date of occurrence

(c) Cemetery or place of interment

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 6:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 28, 1943, to July 28, 1943, and that I last saw her alive on July 27, 1943.

Immediate cause of death

Malignant Hypertension

Duration

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 29 1943

Washington Williams, M.D.

G 06754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06754

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 518 Dolphin St
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 518 Dolphin St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

ANNIE S. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Alexander Williams
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1874

8. AGE: Years 68 Months 7 Days 28 If less than one day
 hr. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name John H. Smith13. Birthplace Md.14. Maiden Name Nancy ?15. Birthplace Md.16 (a) Informant Mrs Charlotte Johnson(b) Address 518 Dolphin St.

17 (a) Burial (b) Date thereof 7-29-43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.
 Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley(b) Address 578 W. Biddle St.

19 (a) (b)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, '43 1943 at 12:15P

21. I certify that death occurred on the date above stated; that I attended deceased from July 18, 1943 to July 26, 1943 and that I last saw him live on July 26, 1943

Immediate cause of death Cerebral apoplexy Duration 2d

Due to Cerebral apoplexy 8d

Due to Hypertension 6mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
 While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Wm. J. RoyAddress 1420 E. Charles July 27, 1943

06755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 06755

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2050 Bank St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 216-01-3199

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or
divorced.

married.

6 (b) Name of husband or wife Francis Wisniewski

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

1884

8. AGE: Years

59

Months

Days

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Packing House

11. Industry or business

FATHER
MOTHER

12. Name

Laurence C. Wisniewski

13. Birthplace

Poland

14. Maiden Name

Josephine

15. Birthplace

Poland

16 (a) Informant Edward Wisniewski

(b) Address 2050 Bank Street

17 (a) Burial

(b) Date thereof 7-31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location Baltimore, Md.

18 (a) Funeral director

George A. Weber

(b) Address

705 S. Ann St.

JUL 29 1943

(b)

(Date registered by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1943 at 9:50 AM

21. I certify that I took charge of the remains described above, held an

autopsy, thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bilateral

infarction of brain

Due to arterio-sclerotic cardiac

vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Frutkin M.D.

Date signed July 29, 1943 Medical Examiner.

G 06756

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06756
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1623 Mulberry St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

53

Months

6

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 7/27/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 29 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 5:11 AM21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

fracture of
skull

Due to

Other Conditions

(Include pregnancy within 2 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury July 25 1943 3:50 P.M.(b) Where did injury occur? Carry & Edmondson Ave(c) Did injury occur at home, on farm, industrial place, in public
place? street While at work? no(d) Means of injury sedition struck by street car23. Signature Robert Lee Graham M.D.Date signed July 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 06757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06757

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2037 E. 32nd. Street**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2037 E. 32nd. Street**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Laura Roycroft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife **Wm. Deal Roycroft**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 8th, 1887**

8. AGE: Years **55** Months **8** Days **21** If less than one day hr. min.

9. Birthplace **Baltimore Md.**
(Town, county, and state)

10. Usual Occupation **none**

11. Industry or business

FATHER 12. Name **Thomas Moore**

13. Birthplace **Md.**

MOTHER 14. Maiden Name **Laura Shaffer**

15. Birthplace **Baltimore Md.**

16 (a) Informant **Miss Margaret Roycroft**

(b) Address **2037 E. 32nd. Street**

17 (a) **Burial** (b) Date thereof **July 30. 43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Lorraine Cem.**
Location **Baltimore Md.**

18 (a) Funeral director **Philip's Moving and**

(b) Address **2034 Orleans St.**

19 (a) **JUL 29 1943** Registrar

VS 3

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 27th, 1943** at **1 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **June 15, 1939** to **July 27, 1943** and that I last saw him alive on **July 27, 1943**

Immediate cause of death

Adema of lungs
Cardiac Renal
Disease

Due to

Other Conditions **My for tension**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury **J. F. Thomas**

23. Signature **J. F. Thomas** Address **3158 Kenford St.** Date signed **7/29/43**

Physician
4 yrs
4 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06758

438366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06758

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-4**

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

3 (a) FULL NAME **John Semmler**

3 (b) If veteran, name war

3 (c) Social Security Account

No. **213-03-0384**

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced. **WIDOWED**

6 (b) Name of husband or wife **Virginia Semmler**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1-27-84**

8. AGE: Years Months Days If less than one day

59

6

0

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation **SALESMAN**

11. Industry or business

12. Name **William Semmler**

13. Birthplace **GERMANY**

14. Maiden Name **FREIDA**

15. Birthplace **GERMANY**

16 (a) Informant **Records**

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **7 31 43**

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Baltimore**

Location

18 (a) Funeral director **Philip Herwig Sons**

(b) Address **2424 Orleans St**

19 (a) **JUL 29 1943**

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **BALTIMORE**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **908 N Chester**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 28** 1943, at **1245 A**

21. I certify that death occurred on the date above stated; that I attended deceased from **July 22** 1943, to **July 28** 1943, and that I last saw him alive on **July 28** 1943.

Immediate cause of death

Cancer of the lung

Duration

? Weeks

Due to

Due to

Other Conditions **Cancer of adrenal & metastases to kidney**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: **? primary Ca of adrenal**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **H. Schwartz**

Address **J. H. H.**

Date signed **7/28/43**

G 06759

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHVG 06759
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day
hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) day (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at

M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary

occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Medical Examiner.

M.D.

Date signed

July 27 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06760

Registered No.

187801

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Leaton & Wilken

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

3 (a) FULL NAME

Mrs. Edna May Vogel

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

white

married

6 (b) Name of husband or wife JOHN VOGEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 21 1880

8. AGE:

Years

Months

Days

If less than one day

63

1

6

hr.

min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JAMES BROWN

13. Birthplace BALTO. MD.

14. Maiden Name SARAH ?

15. Birthplace BALTO. MD.

16 (a) Informant JOHN VOGEL (HUSBAND)

(b) Address 417 N. HIGHLAND AVE.

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof JULY 30/43

(month) (day) (year)

(c) Cemetery or crematory SCHWARTZ CEM.

Location O'DONNELL ST.

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) JUL 29 1943

(Date set by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County BALTO.

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 417

N. Highland Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/43 19 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/19 to 7/27/19 and that I last saw her alive on 7/27/43 19

Immediate cause of death

Cerebral Vascular Accident

Due to

Hypertensive Cardio.

Due to Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. F. Ryan

Address

St. Agnes Hospital

Date signed

7/27/43

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 06761		BALTIMORE CITY HEALTH DEPARTMENT		06761	
ST Joseph's Hosp		CERTIFICATE OF DEATH		122a	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:			
(a) Baltimore City, Maryland		(a) State <u>MD.</u> (b) County <u>Baltimore</u>			
(b) Street address <u>1400 N. Caroline St.</u>		(c) City or town <u>Baltimore</u>			
(c) Hospital or institution: <u>St. Joseph's Hosp.</u>		(d) Street No. <u>1036</u> <u>Emm St.</u>			
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>15 days</u>		(e) Citizen of foreign country? <u>No</u> (Yes or No)			
(e) Length of stay in Baltimore (yrs., mos., or days) <u>60 yrs.</u>		If yes, name country			
3 (a) FULL NAME <u>Adam Kaiser</u>					
3 (b) If veteran, name war <u>none</u>		3 (c) Social Security Account No. <u>none</u>			
4. Sex <u>M.</u>	5. Color or race <u>W.</u>	6 (a) Single, married, widowed, or divorced <u>Married</u>			
6 (b) Name of husband or wife <u>Mary Kaiser</u>		6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Aug 31, 1861</u>					
8. AGE: Years <u>81</u> Months <u>10</u> Days <u>28</u>		If less than one day hr. min.			
9. Birthplace <u>Germany</u> (Town, county, and state)					
10. Usual Occupation <u>Retired Builder</u>					
11. Industry or business					
12. Name <u>John Kaiser</u>					
13. Birthplace <u>Germany</u>					
14. Maiden Name <u>Elizabeth Giroune</u>					
15. Birthplace <u>France</u>					
16 (a) Informant <u>Mrs. Mary Kaiser</u>					
(b) Address <u>1036 Emm St.</u>					
17 (a) <u>Burial</u> (b) Date thereof <u>July 31, 1943</u>					
(c) Cemetery or crematory <u>Holy Redeemer</u>					
Location <u>4430 Belair Road</u>					
18 (a) Funeral director <u>Charles W. Conklin</u>					
(b) Address <u>924 E. Eager St.</u>					
19 (a) <u>JUL 29 1943</u> (b) <u>Thurston</u> Registrar					
20. DATE OF DEATH <u>July 28</u> 19 <u>43</u> at <u>9:15</u> M					
21. I certify that death occurred on the date above stated; that I attended deceased from <u>July 13</u> 19 <u>43</u> to <u>July 28</u> 19 <u>43</u> and that I last saw him alive on <u>July 28</u> 19 <u>43</u>					
Immediate cause of death <u>Uremia</u>					
Due to <u>Arterio-sclerotic vascular</u>					
Due to <u>renal disease</u>					
Other Conditions					
(Include pregnancy within 3 months of death)					
Date of operation <u>July 14/43</u>					
Major findings of operations: <u>Abdominal Uremia</u>					
of autopsy: <u>not done</u>					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at M					
(c) Where did injury occur? (City or town) (County) (State)					
Did injury occur about home, on farm, industrial place, in public place? While at work?					
(Specify type of place)					
(e) Means of injury					
23. Signature <u>William Hupich</u>					
Address <u>St. Joseph's Hosp.</u> Date signed <u>7/28/43</u>					

G 06762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX ✓ G 06762
94a
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos. or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.

(b) County

Baltimore

(c) City or town

Evanston

(If outside city or town limits, write RURAL and give town)

(d) Street No.

13 Western Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Franklin Rineal

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-07-1000

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 1905

8. AGE: Years

Months

Days

If less than one day

37

8

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Book Binder

11. Industry or business

Printing

FATHER
MOTHER

12. Name

George F. Rineal

13. Birthplace

Balto Md

14. Maiden Name

Frances Zieher

15. Birthplace

Balto Md

16 (a) Informant

Agnes M. Duwall

(b) Address

Middle River Md.

17 (a)

Beneal

(b) Date thereof

2 20 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Carmel

Location

6100 Donnell St

18 (a) Funeral director

James Bruckmeyer

(b) Address

1407 Eastern Ave Rd

19 (a)

JUL 29 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1943 at 3:00 P.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary

Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert L. Fackman

M.D.

Date signed

July 27, 1943

Medical Examiner

6763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06763
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 229 N. Schaefer St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Schaefer St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Fem.

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Jas. W. Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 6, 1880

8. AGE:

Years

Months

Days

If less than one day

63

6

20

hr.

min.

9. Birthplace

Somerset Co. Md.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Daniel Waters

13. Birthplace

Md.

MOTHER

14. Maiden Name

Caroline Elzy

15. Birthplace

Md.

16 (a) Informant

Bertha Clark

(b) Address

229 N. Schaefer St

17 (a)

Burial

(b) Date thereof

July 29, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

18 (a) Funeral director

Mrs. Katie R. Williams

(b) Address

322 N. Schaefer St

19

JUL 29 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-26-1943

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1942 to 7-26-1943 and that I last saw him alive on 7-26-1943

Immediate cause of death

Carcinoma

Duration

7 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George C. Page

Address

1816 N. Mount St.

Date signed

8-2-43

06765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06765
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 116 N. Pine St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Willie M. Noakes (NOAKES)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife

John P. Noakes6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.)

JAN - 1912

8. AGE:

Years

Months

Days

If less than one day

3160

hr.

min.

9. Birthplace

ARKANSAS

(Town, county, and state)

10. Usual Occupation

H.W.

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

N.P. Locke

15. Birthplace

Unknown

16 (a) Informant

JESSE W. NOAKES

(b) Address

318 N. GREENE ST

17 (a)

Removal

(b) Date thereof

July 29, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Springfield Mo.

18 (a) Funeral director

Holt & B.M. Watten

(b) Address

Pratt's Trucking Co

19 (a)

7/29/43

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943, at 1 ⁴⁵ AM

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Sodiumfluoride poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury July 27, 1943 11 PM(b) Where did injury occur? 116 N. Pine St(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? no(d) Means of injury Swallowing roach powder23. Signature Robert Lee Graham M.D.Date signed July 28 1943

6766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06766

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. 705-10-4101

4 Sex

MALE WHITE

5. Color or race

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

HESTER M. DOSTER

6 (c) If alive, give age

38 years

7. Birth date of deceased (mo., day, yr.)

JAN 9-1881

8. AGE:

Years

Months

Days

If less than one day

62

6

17

hr

min.

9. Birthplace

BALTIMORE CO. MD

10. Usual Occupation

MACHINIST

11. Industry or business

B & O R.R.

FATHER
MOTHER

12. Name

UNKNOWN

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

HESTER M. DOSTER

(b) Address

335 S. PAYSON ST

17 (a)

BURIAL

(b) Date thereof

July 31-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

MIDDLETOWN CEM

Location

MIDDLETOWN - BALTO CO. MD

18 (a) Funeral director

R.C. + B.M. Walters

(b) Address

TRAFFY STRICKER STS

19 (a)

JUL 29 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

335 S. PAYSON ST

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

JULY 28 1943 12:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1943 to 7/28 1943

and that I last saw him alive on July 24 1943

Immediate cause of death

Hemochromatosis
Hemochromatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Benjamin Miller

Address 2030 Wickers

Date signed

7/28/43

Duration

6 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06767

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3910 Chesley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

3 (a) FULL NAME

Charles Lewis Swanberg

3 (b) If veteran, name war

1st World War

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Mrs Emma Augusta Swanberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 10 1864

8. AGE:

Years

Months

Days

If less than one day

77

1

17

hr.

min.

9. Birthplace

Kirck Sweden

(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

FATHER

12. Name

Lars Swanberg

13. Birthplace

Kirck Sweden

MOTHER

14. Maiden Name

Ingar Oldson

15. Birthplace

Kirck

16 (a) Informant

Mrs Elizabeth Bussey

(b) Address

3910 Chesley Ave

17 (a)

Burial

(b) Date thereof

7 30 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Balto. City Md.

18 (a) Funeral director

Theobald Funeral Home

(b) Address

7401 Belair Rd.

19 (a)

July 29 1943

Huntington, West Virginia

2. USUAL RESIDENCE OF DECEASED:

3910 Chesley Ave

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3910 Chesley Ave

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943 at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1943 to July 27 1943 and that I last saw him alive on July 26 1943

Immediate cause of death

Hypertension causing cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. Fred Roberts

Address

6100 York Rd.

Date signed 7/27/43

G 06768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06768

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4508 Penhurst Ave.
- (c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs. mos. or days

(e) Length of stay in Baltimore yrs. mos. or days

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 4508 Penhurst Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD BALWIN THOMPSON

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Nanle Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1867

8. AGE: Years	Months	Days	If less than one day
75	8	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation retired Foreman

11. Industry or business Gandy Beaf Co.

FATHER 12. Name Otis P. Thompson

13. Birthplace Bush River, Hartford Co.

MOTHER 14. Maiden Name Mary Dunn

15. Birthplace unknown

16 (a) Informant Mrs. Marie M. Thompson

(b) Address 4508 Penhurst Ave.

17 (a) Burial (b) Date thereof 7/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUL 29 1943 (Date received) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1943, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14, 1943, to July 27, 1943, and that I last saw him alive on July 27, 1943.

Immediate cause of death

Mitral Insufficiency

Due to

Due to

Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address 4803 Park Heights M. D. Date signed 7/28/43

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly.

G 06769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06769

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

W. B. S. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2669

Edmondson Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

WILLIAM

Clarence

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Virginia A. Bartholow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/12/1906

8. AGE: Years Months Days If less than one day

36

8

16

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Operator Filling Station

11. Industry or business Own

12. Name William C. Bartholow

13. Birthplace Balto. Co., Md.

14. Maiden Name Julia C. Baer

15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Virginia A. Bartholow

(b) Address 2669 Edmondson Ave.

17 (a) Burial (b) Date thereof 7/31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location

Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUL 29 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943, at 1 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 25 1943 10 A M

(b) Where did injury occur? Catonsville, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Horse fall on rider

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed July 28 1943

G 06770

438646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 06770

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County

(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)(d) Street No. 1130 Manchester Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

M. Spencer Richardson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-28

8. AGE: Years Months Days If less than one day

14 10 28-7 hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Malvin S. Richardson

13. Birthplace Va.

14. Maiden Name Clara?

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 7-29-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Glanster, Va.
Location

18 (a) Funeral director Durward L. Covington

(b) Address 21 W. 25 St. Balt. Md.

19 (a) Date rec'd by registrar Huntingdon Williams, Jr.
Registrar

Jul 29 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943 at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1943 to July 28 1943 and that I last saw him alive on July 28 1943

Immediate cause of death ~~Brain tumor~~ Brain tumorDue to ~~Brain tumor~~

Due to

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation 7/28/43

Major findings of operation Carcinoma

Lung on left

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Mabel H. Harmer M.D.

Address J.H.H.

Date signed 7/28/43

Duration

1 1/2 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06771

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1943, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1943, to July 27, 1943, and that I last saw him alive on July 27, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D. 7/29/43

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

05772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 05772

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2219 Portugal Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Gregorz Bonkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

Married

6 (b) Name of husband or wife Ludwika Gron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1910

8. AGE: Years Months Days If less than one day

10

4

15

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name

Gregorz

13. Birthplace

Poland

14. Maiden Name

Gron

15. Birthplace

Poland

16 (a) Informant Ludwika, Bonkowski, Jr.

(b) Address 2219 Portugal Street

17 (a) Burial (b) Date thereof 7/31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location German Hill Road

18 (a) Funeral director John H. Baker

(b) Address 101 S. Chester St.

19 JUL 29 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2219 Portugal St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1943 to July 27 1943, and that I last saw him alive on July 27 1943.

Immediate cause of death

Myocardial Infarction

Duration 3 days

Due to Chronic Myocarditis

4 yrs.

Due to Coronary

Other Conditions Cardiac Asthma

3 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John V. Geyserich M.D.

Address 1802 Eastern Ave Date signed 7-29-43

G 06774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06774

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Sinai Hospital**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2330 Bryant Ave**
(If rural give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3 (a) FULL NAME

Lena Fannie Yaffe

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced. **Widow**

6 (b) Name of husband or wife

Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1872

8. AGE:

Years

Months

Days

If less than one day

71

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

FATHER

12. Name

Heiman Jacob

13. Birthplace

Russia

MOTHER

14. Maiden Name

Reba

15. Birthplace

Russia

16 (a) Informant

Harris Yaffe

(b) Address

2330 Bryant Ave

17 (a)

Burial

(b) Date thereof

July 30, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Roseale Cemetery

Location

Hamilton Ave

18 (a) Funeral director

Sol Levinson & Bros

(b) Address

1124 1126 W North Ave**JUL 29 1943**

(b)

Huntington W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943 at 4:45 AM21. I certify that death occurred on the date above stated; that I attended
deceased from 19 to 7/28/43

and that I last saw her alive on 7/28/43

Immediate cause of death **Pneumonia Edema**

Duration

Due to **Central Nervous System**Due to **Arteriosclerosis**Other Conditions **Venous Thrombosis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Wm. H. Gallatin

M. D.

Address **Sinai Hospital**Date signed **7/28/43**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06775

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 813 Greenmount avenue

(c) Hospital or institution: -----

(d) Length of stay in hospital or inst. (yrs., mos., or days) -10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 813 Greenmount ave.

(If give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD B. McDERMOTT

3 (b) If veteran, name war
NO3 (c) Social Security Account
No. none

4. Sex

M

5. Color or face

W

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Minnie McDermott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1866

8. AGE: Years Months Days

77

4

23

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Owen McDermott

13. Birthplace Ireland

14. Maiden Name Mary Sheehan

15. Birthplace Ireland

16 (a) Informant Mr. Edward D. McDermott

(b) Address 813 Greenmount avenue

17 (a) Burial (b) Date thereof 7/31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral place

(b) Address

19 (a) (b) 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July, 28 19 43 M

21. I certify that death occurred on the date above stated, that I
ed deceased from May 19 43 to July 28 43
and that I last saw him alive on 7/15 19 43

Immediate cause of death

Carcinoma of
lower lip

Due to

Due to

Other Conditions Carcinomatous

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B. R. O'Leary

Address 3526 E. Enoch Ave. Date signed 7/28/43

Please write in ink. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

05776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6204 Marietta Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6204 Marietta Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Ida M. Neuzentger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife late Louis E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-1875

8. AGE:

77

Years

7

Months

18

Days

hr.

If less than one day, 65 min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

H. W.

11. Industry or business

Own Home

12. Name

13. Birthplace

Baltimore Md.

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mrs. Wiehe

(b) Address

6204 Marietta Ave.

17 (a)

Burial

(b) Date thereof

7-31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western

Location

Edmondson Ave. & Longwood

18 (a) Funeral director

Harry H. Wiehe

(b) Address

4101 Edmondson Ave.

19 (a)

(Date and by whom)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1953, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1953 to 7/27 1953

and that I last saw him alive on 7/27 1953

Immediate cause of death Hypertension

Cardiovascular

Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. H. Wiehe

Address

523 Hartford Rd.

M. D.

Date signed

7/27/53

JUL 29 1953

G 06777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06777

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Balto. - South St. -*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *2 1/2 yrs*

3 (a) FULL NAME

Herrn Clausen

3 (b) If veteran, name war

3 (c) Social Security Account

No. *212-01-7283*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Anna Clausen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec, 19, 1889

8. AGE:

Years

Months

Days

If less than one day

*53**7**9*

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Manager of Intrication

11. Industry or business

*American Oil Co.*FATHER
MOTHER

12. Name

Peter Clausen

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany

16 (a) Informant

Mrs. Anna Clausen

(b) Address

*4312 Colbourne Rd.*17 (a) *Cremation*(b) Date thereof *7-31-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Greenmount

Location

Balto. Md.

18 (a) Funeral director

Harry H. Wilzke

(b) Address

410 E. Monument St.

19 (a)

(Date and by Registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4312 Colbourne Road*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*7-28-**1943, at 4:35 P.M.*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature *Howard J. Maldeis* M.D.Date signed *7-29-43*

Medical Examiner.

G 05778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 05778

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Yes

Months

Days

If less than one day

9. Birthplace:

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Due to Fracture - dislocation of right

Other Conditions Carcinoma of stomach

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 27 1943 6:30 A.M.

(b) Where did injury occur 1514 Ramsay St

(c) Did injury occur at home, on farm, industrial place, in public

place? home

While at work? No

(d) Means of injury Fell off roof

23. Signature

Date signed

Medical Examiner

July 27 1943

G 06779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06779

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.A. Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 402 Lynhurst St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

J. Gordon Barry

3 (b) If veteran, name war

3 (c) Social Security Account
No. 7

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Dorothy S. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1892

8. AGE: Years Months Days If less than one day

51 50 2 10 hr. min.

9. Birthplace New Jersey

(Town, county, and state)

10. Usual Occupation

Civil Engineer

11. Industry or business

B+O

FATHER
MOTHER

12. Name James Barry

13. Birthplace N. J.

14. Maiden Name Mary S. Gordon

15. Birthplace Mass.

16 (a) Informant Mrs. Dorothy S. Gordon

(b) Address 402 Lynhurst St.

17 (a) Burial (b) Date thereof 7-30-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. Md.

18 (a) Funeral director Harry H. Hitzke

(b) Address 4101 E. Annapolis Ave.

19 (a) 7-22-43

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26 1943 8:20 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNeely M.D.

Medical Examiner

Date signed 7/27/43

G 06780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06780

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 Rogers Ave

(c) Hospital or institution:

Methodist Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Rogers Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Dora V. Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife William Schaefer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 24, 1864

8. AGE: Years Months Days If less than one day
79 4 16 3 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Jacob Davault

13. Birthplace Balt., Md.

14. Maiden Name Mary Hickman

15. Birthplace Balt., Md.

16 (a) Informant Miriam C. Coates

(b) Address 2211 St. Rogers Ave

17 (a) Burial (b) Date thereof July 30, '43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balt., Md.

18 (a) Funeral director Mamie Cook Syfer

(b) Address 1600 St. North Ave.

19 (a) (Date rec'd by registrar) JUL 29 1943
Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at 5:15 P M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Carcinoma of
colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Eustace M.D.

Date signed July 27, 1943 Medical Examiner.

437312

G 06781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06781

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JONES HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1909
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry J. Hundertmark

3 (b) If veteran, name war

3 (c) Social Security Account
No. 219-16-9839

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-25

8. AGE: Years 17 Months 8 Days 21 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Chaffer

11. Industry or business

12. Name Louis Hundertmark

13. Birthplace Md

14. Maiden Name Anna Sass

15. Birthplace Md

16 (a) Informant Records

(b) Address JONES HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/30/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Cross
Location Brooklyn Md

18 (a) Funeral director William M. Mareck

(b) Address 715 E. 1st St. Williams, Md

19 (a) JUL 29 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943, at 8:25

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943, July 27 1943 and that I last saw him alive on July 27 1943

Immediate cause of death

Circulatory Failure

Due to Anemia

Due to Acute myeloid leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. P. Freeman Jr.
Address Johns Hopkins Hospital signed 7/27

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. If physician, please write for cause of death clearly and legibly.

5782

JL - 16169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06782

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. 12-3-10
(yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 906 Morris St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Amanda Turner

3 (b) If veteran, name war

3 (c) Social Security Account

No. ?

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1911

8. AGE: Years Months Days If less than one day
62 ? ? ? hr. min.

9. Birthplace Petersburg, Va.

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 29 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUL 29 1943 Huntington Williams

VF 120

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1943 at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/25 1943 and that I last saw her alive on 7/25 1943.

Immediate cause of death

Cerebral accident; 20 mins.
post pulmonary embolus
Due to Hypertensive C.V. disease 12 yrs.

Due to

Other Conditions

Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Sarginan

Address Balto. City Hosp Date signed 7/16

PHYSICIAN

Underline the cause to which death should be charged statistically.

0269

G 06783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06783
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1942, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940, to July 25 1942, and that I last saw him alive on July 25 1942.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

JUL 29 1942

VS 3

06784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06784
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Cabot & Swatara St.*
 (c) Hospital or institution: *Mary Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *1 mo.*
 (e) Length of stay in Baltimore (yrs., mos., or days) *1 mo.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Frederick*
 (c) City or town *Frederick*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *Visitation Court*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

Sister Mary Alphonse Muth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Jan 20th, 1868

8. AGE:

Years

Months

Days

If less than one day

*75**6**9**hr. — min.*

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Religious

11. Industry or business

FATHER

12. Name

Michael Joseph Muth

13. Birthplace

Bavaria

MOTHER

14. Maiden Name

Mary Josephine Koltzshy

15. Birthplace

Maryland

16 (a) Informant

Sister Fidelis

(b) Address

*Frederick Md*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

7/31/43

(month) (day) (year)

(c) Cemetery or crematory

Visitation Cemetery

Location

Frederick, Md

18 (a) Funeral director

Harry E. Canty Co

(b) Address

Frederick, Md

JUL 30 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from *July 19 1943* to *July 29 1943*, and that I last saw her alive on *July 29 1943*.

Immediate cause of death

Cerebral artery failure
 Due to *Complications of the urinary bladder*
 Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Cystectomy - 7/19/43*

Major findings of operation:

Advanced Cancer of Bladder

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Frederick Muth

Address

*Mary Hospital*Date signed *July 29 1943*

Physicians: please write the causes of death clearly and legibly.

06785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06785
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20.8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 544 Monroe Alley
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Young

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex M

55

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE: Years 55 Months Days If less than one day
hr. min.9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name John Young
13. Birthplace Va.
14. Maiden Name Annie?
15. Birthplace N. C.16 (a) Informant Miss Elizabeth Brown
(b) Address 531 W. Biddle St.17 (a) Burial (b) Date thereof 7-30-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Auburn
Location Balt. Md.18 (a) Funeral director Mrs. Frances A. Hempley
(b) Address 578 St. Biddle St.

19 (a) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943 at 10:00 AM

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graton M.D.

Date signed July 29 1943

6786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06786
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1806 E. Madison*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Purnell Swan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *11-22-42*

8. AGE:

Years

Months

Days

If less than one day

*8**6*

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Percy Swan

13. Birthplace

14. Maiden Name

Mary - ?

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) *Burial*

(b) Date thereof

7-30-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

*Mt. Calvary Ave.*Location *Anne Arundel Co. Md.*

18 (a) Funeral director

Mrs. Frances A. Hummel

(b) Address

Huntington Williams, M.D.

JUL 30 1943

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 28* 19*43* at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *July 28* 19*43* to *July 28* 19*43* and that I last saw him alive on *July 28* 19*43*

Immediate cause of death

Circulatory failure

Duration

4 hr.

Due to

dysentery

Due to

(20)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

James Kaye

Address

James Kaye

Date signed

7/29

6787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 ✓ Registered No. 06787

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3908 Ferndale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Ferndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME

Florence E. Power

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or Edward N. Power

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 28th 18728. AGE: Years Months Days If less than one day
71 3 1 hr. min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

Ref

12. Name Howard Maynard

13. Birthplace Md.

14. Maiden Name Sarah Chiswell

15. Birthplace Md.

16 (a) Informant Mrs Arnold Goring Jr.

(b) Address 3908 Ferndale Ave

17 (a) Burial (b) Date thereof 8/2/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment Mt Olive

Location Frederick Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) JUL 30 1943 (b) Registrar William M. P.

(Date rec'd by registrar) (Signature)

VB 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 2 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Cerebral
hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed July 29 1943

G 06788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06788
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-29-43

19

at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1943 to July 19 1943 and that I last saw him alive on July 19 1943.

Immediate cause of death

Ca of Stomach

Duration

3 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 30 1943

VB 154

06789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06789

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5410 Purlington Way

(c) Hospital or institution:

at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) City Baltimore City

(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5410 Purlington Way

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country No

3 (a) FULL NAME

RICHARD CALVERT CONKLIN

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August-8-1933

8. AGE: Years Months Days If less than one day

9

11

21

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

none

FATHER
MOTHER

12. Name William T. Conklin, Jr.

13. Birthplace Galveston, Texas

14. Maiden Name Elizabeth W. Egerton

15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Wm. T. Conklin, Jr. (father)

(b) Address 5410 Purlington Way, City.

17 (a) Burial (b) Date thereof July-31-43.

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland.

18 (a) Funeral director Stewart & Mowan Company

(b) Address 108 W. North Avenue, City.

19 (a) JUL 30 1943

(b) Date of registration

Huntington W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943. at 4 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from July 1940. to July 1943. and that I last saw him alive on July 1943.

Immediate cause of death

Diabetes Mellitus

Duration

5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy. No gross findings

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington W. Williams, M.D.

Address 1011 N. Charles St.

Date signed 7/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06790
Registered No.

06790

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 432 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Emma Venev

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1902

8. AGE: Years 41 Months 2 Days 9 hr. min.

9. Birthplace Richmond Co. Va.
(Town, county, and state)

10. Usual Occupation Day Worker

11. Industry or business

12. Name Carrol Dawson Venev

13. Birthplace Va.

14. Maiden Name unknown

15. Birthplace

16 (a) Informant John J. Venev

(b) Address 505 Myrtle Ave.

17 (a) Burial (b) Date thereof 8/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Marsaw

Location Marsaw Va.

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) 30 1943 (b) Registrar Thos. J. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 1:40 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from (9) June 1943 to July 29, 1943, and that I last saw her alive on July 25, 1943.

Immediate cause of death

Cancer of Uterus

Duration 6 mos.

Due to Usual cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature D. Grant Smith

Address 3624 W. Biddle St. Date signed 7-30-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06791
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

MINNIE GOULD GIBBONS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

FEM.

5. Color or race

WHITE

6 (a) Single, married, widowed, or
divorced

WIDOWED

6 (b) Name of husband or wife

EDWARD E. GIBBONS

DECEASED 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 14, 1877

8. AGE:

Years

Months

Days

If less than one day

66

5

15

hr.

min.

9. Birthplace

BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation

AT HOME

11. Industry or business

12. Name

JOHN R. GOULD

13. Birthplace

Baltimore, Md.

14. Maiden Name

AMELIA MEGE

15. Birthplace

Baltimore, Md.

16. Name

JAMES ROBERT GIBBONS

(b) Address

3 ELMHURST ROAD

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

7/31/43

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Baltimore, Md.

19 (a)

JUL 30 1943

(Date of registration)

Registrar

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 29 1943, 4:30 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from APRIL 1939 to JULY 29, 1943.
and that I last saw her alive on JULY 29, 1943.

Immediate cause of death

CARCINOMA OF
THE LIVER

Due to

Due to

Other Conditions CARCINOMA OF
INTESTINES

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address

3524 Greenmount Rd.

Baltimore, Md.

JUL 29 1943

Duration

4 YRS

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06792

BALTIMORE CITY HEALTH DEPARTMENT

G 06792

Registered No.

CERTIFICATE OF DEATH

937

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

700 W 40th St.

(c) Hospital or institution:

Home for Incurables 13-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W 40th St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Miss Emma Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1859

8. AGE: Years

84

Months

2

Days

28

If less than one day

hr.

min.

9. Birthplace Chester, Queen Anne's County

(Town, county, and state) Maryland

10. Usual Occupation Nurse

11. Industry or business

FATHER

12. Name Mr. Samuel Smith

13. Birthplace

MOTHER

14. Maiden Name Miss Anna Beel

15. Birthplace Green Anne's County

16 (a) Informant Miss Letta Perkins

(b) Address 700 W 40th St.

17 (a) Burial (b) Date thereof 7-31-43

(burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Mr. J. J. J. J.

(b) Address 11 E. Chase St.

19 (a) JUL 30 1943

(Date for filing)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943, at 6¹⁵ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1938, to July 29 1943, and that I last saw her alive on July 28 1943.

Immediate cause of death

Cerebral Hemorrhage with Right Hemiplegia

Due to Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas Conrad W. H. J.

Address 11 E. Chase St. Date signed 7/29/43

Baltimore Md.

Duration

2 days

20 years approx

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

06793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

06793

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 307 N. Gilmore St
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 307 N. Gilmore Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Thomas Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 15 1888

8. AGE:

Years

Months

Days

If less than one day

5403913

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Thomas P. Jackson

13. Birthplace

Va.

14. Maiden Name

Louise Newman

15. Birthplace

Va.

16 (a) Informant

Rhodie Palmer

(b) Address

1700 Brent St

17 (a)

Burial

(b) Date thereof

8/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

at Auburn

Location

MD

18 (a) Funeral director

Sec. H. Nelson

(b) Address

1303 Presatman St.JUL 30 1943
(Date rec'd by registrar)William M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-28-1943 at 11:10 P.M.21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Howard J. Mulderis M.D.

Medical Examiner.

Date signed 7-29-43

06794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 06794

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3515 - Menlo Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind(b) County Baltimore(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3515 - Menlo Drive

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Alexander Cullum

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-09-3121

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Ora Cullum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-1878

8. AGE:

Years

Months

Days

If less than one day

6527

hr.

min.

9. Birthplace Pikesville Maryland

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Moses Cullum13. Birthplace Maryland14. Maiden Name Sarah Squish15. Birthplace Maryland16 (a) Informant Mrs. O. F. Cullum(b) Address 3515 Menlo Drive17 (a) Burial (b) Date thereof July 30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge CemLocation Baltimore Ind.18 (a) Funeral director Mamie Cook Sykes(b) Address 1600 West North Ave19 JUL 30 1943 (b) Huntington Williams, M.D.

(Date and day registered)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943, at 1 26 P M21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17, 1943 to July 27 1943, and that I last saw him alive on July 26 1943.

Immediate cause of death

Chr. Myocarditis

Due to

Due to

Other Conditions De compressionChr. Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George E. Shannon M.D.Address 810 Madison St Date signed 7/27/43

M. D.

correct age is especially important. Physicians: please write the cause of death clearly and fully.

06795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 06795

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7409 G. Ray Ayrette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

3 (a) FULL NAME

Dorothy Criswell

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

JOHN CRISWELL

(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

Aug 9-1868

8. AGE:

Years

Months

Days

If less than one day

74

11

70

hr.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual Occupation

11. Industry or business

H. WIFE

FATHER
MOTHER

12. Name

UNKNOWN

13. Birthplace

GERMANY

14. Maiden Name

UNKNOWN

15. Birthplace

GERMANY

16 (a) Informant

JOHN CRISWELL

(b) Address

7409 G. Ray Ayrette Ave

17 (a)

BURIAL

(b) Date thereof

Aug 1-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

OAKLAWN

Location

B. & C. Co. Md

18 (a) Funeral director

P. H. & M. Wallace

(b) Address

PRATT STRICKER STS

JUL 30 1943

(c) Signature of Minister

William H. B.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7409 G. Ray Ayrette Ave

(e) Citizen of foreign country?

(If rural, give location)

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943 at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1943 to July 29 1943, and that I last saw him alive on July 27 1943.

Immediate cause of death

arteriosclerotic heart disease

Duration

unknown

Due to.

Due to.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William H. B.

Address

206 S. John St.

Date signed

7-30-43

G 06796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 06796
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HENRY R Meisel

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or
divorced.MARRIED

6 (b) Name of husband or wife

ANNA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-91

8. AGE:

Years

Months

Days

If less than one day

5172

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Cigar Store

11. Industry or business

12. Name John Meisel

13. Birthplace

Md14. Maiden Name Mollie Wilmot

15. Birthplace

D.C.16 (a) Informant Records

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) Burial (b) Date thereof 8-2-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Woodlawn CemLocation Balto. Md.

18 (a) Funeral director

Wm C Muller Inc

(b) Address

2438 E Oliver StJUL 30 1943
Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) CountyCity or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 2528 E Oliver
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 9:05 PM21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1943 to July 29 1943, and that I last saw him alive on July 29 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NOT done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. S. Cross Jr.

M. D.

Address J. H. H.

Date signed

G 06797

BALTIMORE CITY HEALTH DEPARTMENT

G 06797

CERTIFICATE OF DEATH 46 E

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 Airquith Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Airquith rural give location

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 2, 1878

8. AGE: Years 64 Months 7 Days 26 If less than one day hr. 26 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

12. Name George Schuessler

13. Birthplace Baltimore Md.

14. Maiden Name Elizabeth Korn

15. Birthplace York Pennsylvania

16 (a) Informant S. M. Staw. Nostka

(b) Address 901 Airquith Street

17 (a) Burial (b) Date thereof July 31/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location

18 (a) Funeral director S. M. Staw. Nostka

(b) Address 811 N Wolfe St

19 (a) JUL 30 1943

(Date signed by registrar) Huntington Williams, M.D.

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from November 9, 1941, to July 19, 1943, and that I last saw him alive on July 29, 1943.

Immediate cause of death

Inoperable Carcinoma

Due to Cecum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. J. Turley M. D.

July 30 43 Date signed

10 E North Ave

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Airgum St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Lester Anita Hammer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/24

8. AGE:

Years

Months

Days

If less than one day

68 69

9

4

hr.

min.

9. Birthplace

Penn.
(Town, county, and state)

10. Usual Occupation

Religion

11. Industry or business

FATHER

12. Name Matthias Hammer

13. Birthplace Germany

MOTHER

14. Maiden Name Sabina Zeller

15. Birthplace Germany

16 (a) Informant Sr. Hosket

(b) Address 901 Airgum St

17 (a) Burial (b) Date thereof July 31/43

(Burial, cremation, or removal)

(c) Cemetery or crematory Mt St. Mary's

Location

18 (a) Funeral director Geo M. Smith Sr

(b) Address 84 N W 1st St

19 (a) Date of death July 30 1943

V8 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1943 to 7/29 1943, and that I last saw him alive on 7/29 1943

Immediate cause of death

Acute Myocardial Infarction

Duration

1 day

Due to Adrenal CA. Pyelonephritis and

Due to Cerebral Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/28/43

Major findings of operation:

Adrenal Carcinoma - Pyelonephritis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard S. Rude

Address Bon Secours Hosp Date signed 7/29/43

G 06799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06799

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

JUL 30 1943

VB 144

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attend-
ed deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

7/30/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important

G 06800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06800

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Willie Smith

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color

Negro

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife

Grace Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 1904

8. AGE:

Years

Months

Days

If less than one day

35

9

hr.

min.

9. Birthplace

Kentucky

(Town, county, and state)

10. Usual Occupation

Chippin

11. Industry or business

Ship yard

FATHER
MOTHER

12. Name

Henry Smith

13. Birthplace

Kentucky

14. Maiden Name

Mary Smith

15. Birthplace

Kentucky

16 (a) Informant

Miss Virginia Smith (Daughter)

(b) Address

1010 Armistead Way

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Ashland Kentucky

(d) Location

Kentucky

18 (a) Funeral director

Leonard G. Ruck

(b) Address

5395 Hobfild Rd.

19 JUL 30 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

8 E. York St.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30

1943, at

105 St.

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of

skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

July 29 1943 9:30 PM

(b) Where did injury occur?

Bethlehem Ship yard

(c) Did injury occur at home, on farm, industrial place, in public

place? in industrial

(d) Means of injury

Fall into hold of ship

23. Signature

Robert Lee Graham

M.D.

Date signed

July 30 1943

G 06801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06801

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd. & Calvert sts.

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs.(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2201 Hamilton Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Mrs. George C. Braun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1887

8. AGE: Years

55

Months

10

Days

6

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Painter

11. Industry or business

12. Name

Jacob Braun

13. Birthplace

Germany

14. Maiden Name

Catherine Johansen

15. Birthplace

16 (a) Informant

Mary C. Braun

(b) Address

2201 Hamilton Ave.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8-2-43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Harbor Rd.19 (a) 20 1943

(Date of registration)

Wilmington, Delaware

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943. 5:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1943. to July 29 1943. and that I last saw him alive on July 29 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

?Due to Hypertensive cardiac -vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Montgomery Jr.Address 332 St. University Date signed 29/43

G 06802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06802

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1816 E. 28th Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1816 E 28th Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret M. Hahn

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

white6 (a) Single, married, widowed, or
divorced.Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 8, 1861

8. AGE:

Years

Months

Days

If less than one day

82320

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

FATHER

12. Name

John Hahn

13. Birthplace

Germany

MOTHER

14. Maiden Name

Gertrude Schmidt

15. Birthplace

Germany

16 (a) Informant

Mrs. Pamela Katzenberger

(b) Address

Middle River

17 (a)

Burial

(b) Date thereof

7-31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Harford Road

19 (a) Date of death

July 28, 1943

(b) Signature of registrar

Wilmington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1943, at M21. I certify that death occurred on the date above stated; that I attended deceased from June 19, 1943 to July 28, 1943.and that I last saw her alive on July 28, 1943.

Immediate cause of death

Myocardial Infarction
and Cardiac Dilatation

Duration

1 year
10 days

Due to

Due to

Other Conditions

Generalized atherosclerosis
Complete Obstruction of Coronaries

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Albert E. Baer

Address

2025 Church AveDate signed 7/29/43

G 06803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06803

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 837 W. Ostend ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 837 W. Ostend ST

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby JeanEades

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years Months Days If less than one day

2

hr. min.

9. Birthplace

Bethesda, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Robert Eades13. Birthplace Quindel Co Md14. Maiden Name Hester Eades Jones15. Birthplace Baltimore Md16 (a) Informant Hester Eades mother(b) Address 837 Ostend St17 (a) Burial (b) Date thereof July 30/43

(Burial, cremation, or removal)

(c) Cemetery or crematory St Calvary

Location

18 (a) Funeral director Elroy O Wilson(b) Address 1000 Blantley19 (a) Jul 30 1943 (b) Registrar Huntington Williams, M.D.

VB 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Infantiledysentery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert C. Graham M.D.

Medical Examiner.

Date signed

July 29 1943

6804

MJ-80276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06804

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos., 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1906 Mosher St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ruth Herman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Female5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Guy E. Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1889

8. AGE: Years 54 Months 5 Days 1 If less than one day hr. min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Robert Tippet (D)

13. Birthplace Pennsylvania

14. Maiden Name Aletta Raidabaugh

15. Birthplace Pennsylvania

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Date of death 8-2-43

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

(b) Date thereof

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1943 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/29 1943.

and that I last saw her alive on 7/29 1943.

Immediate cause of death Acute Cordiac Failure; Pulmonary infection

Due to Hypertensive arteriosclerosis - (C.V. disease)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Card hypertrophy; arteriosclerosis; multiple pat. infarcts

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sargman

Address 10 C H

Date signed 7/30

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1172G 06805
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument + Rutland

(c) Hospital or institution: Sinai Hospital 26-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED

(a) State Ind

(b) City Balt

(c) City or town

(If outside city or town limit, write RURAL and give location)

(d) Street No. 708 S. Ponca St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Steve Sfeckas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 26 - 1887

8. AGE: Years

Months

Days

If less than one day

53

8

34

hr.

min.

9. Birthplace

Greece

(Town, county, and state)

10. Usual Occupation

Postmaster

11. Industry or business

Self

12. Name

Peter Sfeckas

13. Birthplace

Greece

14. Maiden Name

Mary Xenakis

15. Birthplace

Greece

16 (a) Informant

Peter Sfeckas

16 (b) Address

710 S. Ponca St

17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof

Aug. 2 - 48

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Woodlawn

18 (a) Funeral director

W. J. Morgan Co.

(b) Address

1217 S. Ponca St

19 (a)

JUL 31 1948

(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30, 1943, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27, 1943, to July 30, 1943, and that I last saw him alive on July 30, 1943.

Immediate cause of death: Respiratory collapse

Duration

3 days

Due to

Pneumonia

Due to

Post-operative

Other Conditions

Pulmonary edema,

peritonitis, pericarditis, gastroenteritis

(Include pregnancy within 3 months of death)

Date of operation

July 28, 1943

Major findings of operation: Ductal atresia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Henry Drusman

M. D.

Address

Sinai Hosp

Date signed

7-30-43

G 06806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 06806

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison + Linden*

(c) Hospital or institution:

md. Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. *2785 Alameda Ave*

(If rural, give location)

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country

3 (a) FULL NAME

Miss Catherine Brenner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 7 1893

8. AGE:

Years

Months

Days

If less than one day

*49**9**23*

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Brenner

13. Birthplace

Balto. md.

14. Maiden Name

Mary Lee

15. Birthplace

Balto. md.

16 (a) Informant

Charles L. Brenner

(b) Address

2825 Northern Parkway

17 (a)

Burial

(b) Date thereof

8/3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Parkwood

Location

Parkville Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

11/3/43

(Date for registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 30* 1943 at *1 A* M21. I certify that death occurred on the date above stated; that I attended deceased from *July 9* 1943 to *July 30* 1943, and that I last saw *her* alive on *July 29* 1943.

Immediate cause of death

Carcinomatous

Due to

Carcinoma of ovary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *L. Herman Williams*

M. D.

Address *md. Gen. Hosp* Date signed

Please write the causes of death clearly and legibly.

06807

M⁺ 82536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06807

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5930 Kavan Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Alonzo Willing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie Mae Willing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1875

8. AGE: Years Months Days If less than one day
68 5 7 hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Henry Willing

13. Birthplace Maryland

14. Maiden Name Mary Brown

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8/2/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director William Cook Inc

(b) Address

19 (a) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1943 at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1943 to 7-29 1943, and that I last saw him alive on 7-29 1943.

Immediate cause of death

Carcinoma of Bladder

Due to

Due to

Other Conditions Gen Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 7-29-43

Major findings of operation Cystoscopy -

Ca of Bladder

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Donald B. Hill

Address Baltimore City Hosp

Date signed 7-30-43

G 06808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *830*

G 06808

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **1838 W. Baltimore St**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *20*(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County**Baltimore**

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. **1838 W. Baltimore St**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John A. Ewing

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex **Male**5 Color or race **White**6 (a) Single, married, widowed, or divorced **Married**6 (b) Name of husband or wife **Neva Ewing**6 (c) If alive, give age **58** years7. Birth date of deceased (mo., day, yr.) **Sept 4th, 1858**8. AGE: Years **84** Months **00** Days **24** If less than one day
hr. - min.9. Birthplace **Baltimore County, Md.**

(Town, county, and state)

10. Usual Occupation **Retired**

11. Industry or business

12. Name **William Ewing**13. Birthplace **Maryland**14. Maiden Name **Elizabeth Ann Coursey**15. Birthplace **Maryland**16 (a) Informant **Mrs Neva Ewing**(b) Address **1838 W. Baltimore St**17 (a) **Burial** (b) Date thereof **July 31st**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Loudon Park**Location **Baltimore, Md.**18 (a) Funeral director **F. B. Wippert & Son**(b) Address **Eutaw Place & Lenvale St**19 (a) **JUL 31 1943**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 28th, 1943** **4.05M**21. I certify that death occurred on the date above stated; that I attended deceased from **July 26, 1943** to **July 28, 1943**, and that I last saw him alive on **July 28, 1943**.

Immediate cause of death

Coronary**Heart Disease**Due to **Coronary****Dilatation**Due to **Old age**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **James Graham MacFarlane** M. D.
Address **16 Baltimore** Date signed **7-29-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

06809

NJ-82839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06809
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1236 N. Gay St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Baby Boy Jackson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1943

8. AGE:

Years

Months

Days

If less than one day

4 hr. 20 min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Sattie Jackson

13. Birthplace

Georgia

MOTHER

14. Maiden Name

Betty Webb

15. Birthplace

Richmond, VA.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Cremation

(b) Date thereof

gas am

7/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore City Hospital

Location 4940 Eastern Ave, Balt., Md.

18 (a) Funeral director

(b) Address

19 JUL 31 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-1943 at 3 A. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7-24-1943 to 7-25-1943
and that I last saw him alive on 7-25-1943.

Immediate cause of death

Congenital atelectasis

Duration

5 hrs

Due to

Pneumonia

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore City Date signed 7-26-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 6

G 06810

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State M.D. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 827 W. Fayette St.
(If rural give location)

(e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME

Emory Lay

3 (b) If veteran, name war

World War I

3 (c) Social Security Account No. ?

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mossie Lay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1899

8. AGE: Years Months Days If less than one day
44 7 ? hr. min.

9. Birthplace

Tennessee
(Town, county, and state)

10. Usual Occupation Reamer and Bolter, Fairfield

11. Industry or business

Ship yards

FATHER

12. Name

Calab Lay

13. Birthplace

Tennessee

MOTHER

14. Maiden Name

Vining Trammel

15. Birthplace

Kentucky

16 (a) Informant S. T. Francis

(b) Address 2435 Smith Ave Lakeland Md

17 (a) Burial (b) Date thereof 7-31-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory location
Baltimore National
Frederick Rd.

18 (a) Funeral director A. Lee Odey

(b) Address 7644 York Rd.

19 (a) (b) 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1943, to July 28 1943, and that I last saw him alive on July 28 1943.

Immediate cause of death

Meningococcus Meningitis

Duration

2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. L. Jones

Address Sydenham Hosp Date signed 7/30/43

G 06811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06811

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 816-12-0379

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

(Date rec'd by registrar)

JUL 31 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1943, at 5:28 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1943, to 7/30 1943, and that I last saw him alive on 7/30 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Date signed 7/30/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06812
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account

No. 705-05-7549

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29

1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06813

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Thomas

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-12-4956

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 30 1890

8. AGE:

Years

Months

Days

If less than one day

53

52

30

hr.

min.

9. Birthplace

Turkey

(Type, county, and state)

10. Usual Occupation

Cook

11. Industry or business

FATHER

12. Name

Demetre Papachriston

13. Birthplace

Turkey

MOTHER

14. Maiden Name

Mary Manis

15. Birthplace

Turkey

16 (a) Informant

Mr Agnew

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

7/31/43

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn

18 (a) Funeral director

Sunward & Co. Corington

(b) Address

21 N. 25 St.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7202

Hanford Rd

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1943 at 11 PM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Depressed fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 24 1943 5 PM

(b) Where did injury occur? Hanford Rd & Lingamore Ave

(c) Did injury occur at home, on farm, industrial place, in public place? ☒ street Baltimore County While at work? no

(d) Means of injury Pedestrian struck by auto

23. Signature

Robert L. Graham

M.D.

Date signed

July 28 1943

06814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06814

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2623 N. Charles St.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2623 N. Charles St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country.

3 (a) FULL NAME

Charles H. Poumairat

3 (b) If veteran, name war

✓

3 (c) Social Security Account

No.

✓

4. Sex
male5. Color or race
white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife Alice Seidenstricker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 22, 1886

8. AGE:

Years

Months

Days

If less than one day

86

7

7

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

retired

11. Industry or business

41

FATHER
MOTHER

12. Name Charles H. Poumairat

13. Birthplace Baltimore

14. Maiden Name Caroline Jackson

15. Birthplace Phila., Pa.

16 (a) Informant Caroline M. Stewart

(b) Address 3021 N. Calvert St.

17 (a) Burial (b) Date thereof July 31, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory Laurel Ridge

Location Pikesville, Baltimore, Md.

18 (a) Funeral director John A. Mitchell

(b) Address 1900 Eutaw Place

19 (a) (b) Dr. J. H. Williams

VB 156

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1943, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended and deceased from Ph 1936 to July 29, 1943 and that I last saw him alive on 7/28/1943

Immediate cause of death

Myocardial
infarction - chronic

Duration

Indefinite

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 1403 Park Ave.

Date signed 7/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06815

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 643 Washington Blvd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 643 Washington Blvd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

DR. WALTER R. MERRIAM

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Julia D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/9/1876

8. AGE: Years

66

Months

11

Days

20

If less than one day

hr.

min.

9. Birthplace Glasgow, Scotland

(Town, county, and state)

10. Usual Occupation

Dentist

11. Industry or business

OWN

FATHER
BROTHER

12. Name Robert W. Merriam

13. Birthplace Portland, Maine

14. Maiden Name Jane Kenmore

15. Birthplace Truand, Scotland

16 (a) Informant Mrs. Julia D. Merriam

(b) Address 643 Washington Blvd.

17 (a) Burial (b) Date thereof 8/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine Cen.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUL 31 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1943, at 12:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1, 1935, until July 29, 1943, and that I last saw him alive on July 29, 1943.

Immediate cause of death

CARDIOVASCULAR DISEASE

Due to ARTERIO SCLEROSIS

Due to

Other Conditions BENIGN PROSTATIC HYPERTROPHY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: NO

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward J. Milan M.D.

Address 6824 Wisconsin Ave Date signed 7-30-43

Duration

942

1935

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06816

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **405 N. Ellwood Ave.**
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **405 N. Ellwood Ave.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Nicholas F. Glos

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife **Augusta S. Glos**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 15, 1888**

8. AGE:

Years

Months

Days

If less than one day

56**10****15**

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Produce Dealer

11. Industry or business

FATHER
MOTHER

12. Name

---Glos

13. Birthplace

Balto. Md.

14. Maiden Name

Unknown

15. Birthplace

Balto. Md.16 (a) Informant **Mrs. Augusta S. Glos**(b) Address **405 N. Ellwood Ave.**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **July 1, 1943**

(c) Cemetery or crematory

Moreland Mem. Park

Location

Balto. Md.

18 (a) Funeral director

Philip

(b) Address

2024 Orleans St.19 (a) **July 31, 1943**

(b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 30/43** 19 **43** at **M**21. I certify that death occurred on the date above stated; that I attended deceased from **6-9** 19 **43** to **7-30** 19 **43** and that I last saw **him** alive on **7/16** 19 **43**.

Immediate cause of death

Hypertensive Crisis - 6th week
Heart - Arteriosclerotic Fibrosis 2 yrs

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Dr. John J. Newcomb** M. D.Address **2529 East Ave** Date signed **7/31/43**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06817

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
1300 Aisquith Street
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs.

3 (a) FULL NAME

Henry M. Lyell

3 (b) If veteran, name war

World War # 1

3 (c) Social Security Account

No. None

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Single

6 (b) Name of husband or wife
None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th, 1892

8. AGE: Years Months Days If less than one day
51 2 9 min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation Proprietor (Tavern)

11. Industry or business own Business

12. Name Richard Lyell

13. Birthplace Virginia

14. Maiden Name Anna Meteir

15. Birthplace Unknown

16 (a) Informant Mrs. Anna Rosenberger

(b) Address 1300 Aisquith St.

17 (a) Burial (b) Date thereof Aug. 2, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.

Location Frederick Rd. Balto. Md.

18 (a) Funeral director George B. Ruth, Inc.

(b) Address 1735 Harford Avenue

JUL 31 1943

VB 130

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1300 Aisquith Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29th, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1942, to July 29, 1943.

and that I last saw him alive on July 28, 1943.

Immediate cause of death

Cardio-Vascular Disease

Duration

?

Due to

Due to

Other Conditions

Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph S. Blum

Address 1206 E. Preston St. Date signed 7/29/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06818

Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>1218 Brentwood Avenue</u> (c) Hospital or institution: <u>10</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>None</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>				2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md.</u> (b) County <u>City</u> (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>1218 Brentwood Ave.</u> (If usual give location) (e) Citizen of foreign country? <u>NO</u> (Yes or No) If yes, name country			
3 (a) FULL NAME <u>John Phillip Wess</u>							
3 (b) If veteran, name war <u>None</u>				3 (c) Social Security Account No. <u>None</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6 (a) Single, married, widowed, or divorced. <u>Married</u>			
6 (b) Name of husband or wife <u>Mary Loretta Tolley</u> 6 (c) If alive, give age <u>65 years</u>							
7. Birth date of deceased (mo., day, yr.) <u>8/16/1882</u>							
8. AGE: Years <u>60</u>		Months <u>11</u>		Days <u>14</u>		If less than one day <u>10</u> min.	
9. Birthplace <u>Baltimore Md.</u> (Town, county, and state)							
10. Usual Occupation <u>Laborer</u>							
11. Industry or business <u>Dept. Highway (Balto.)</u>							
12. Name <u>Adolph Wess</u>							
13. Birthplace <u>Germany</u>							
14. Maiden Name <u>Mary Anna (Houglia)</u>							
15. Birthplace <u>Germany</u>							
16 (a) Informant <u>Mrs. Mary L. Wess (Wife)</u> (b) Address <u>1218 Brentwood Ave.</u>							
17 (a) Burial <u>Burial</u> (b) Date thereof <u>Aug. 3, 1943</u> (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory <u>Meadow Ridge</u> Location <u>Washington, D.C.</u>							
18 (a) Funeral director <u>George J. Ruff</u> (b) Address <u>1735 Harford Ave.</u>							
19 <u>JUL 31 1943</u> (b) Registrar <u>Thurston Williams, M.D.</u>							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>July 30, 1943</u> at <u>11:55 AM</u> 21. I certify that death occurred on the date above stated; that I attended deceased from <u>Feb 1942</u> to <u>July 30, 1943</u> and that I last saw him alive on <u>July 1942</u> Immediate cause of death <u>Pro. Gastric Hemorrhage</u> Due to <u>Carcinoma of Stomach</u> Due to <u>about 1 yr</u> Other Conditions (Include pregnancy within 3 months of death) Date of operation Major findings of operations of autopsy: 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence <u>at</u> <u>M</u> (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? <u>While at work?</u> (Specify type of place) (e) Means of injury <u>S. Hightower</u> 23. Signature <u>S. Hightower</u> Address <u>888 W. Lombard St.</u> Date signed <u>7.30.43</u>							

G 06819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06819

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **1009 S. Bouldin St**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **30 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
 (c) City or town **Baltimore Md.**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **1009 S. Bouldin St.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Earl L. Leader

3 (b) If veteran, name war

World War 1

3 (c) Social Security Account

No. **213-10-7716**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Frances Leader

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 20 1899

8. AGE:

Years

Months

Days

If less than one day

43**9 10****20 11**

hr.

min.

9. Birthplace **Harrisburg Pa.**

(Town, county, and state)

10. Usual Occupation **Gaurd At Chev.**11. Industry or business **Motor Co.**12. Name **Ralph Leader**13. Birthplace **Penn. Pa.**14. Maiden Name **Mabel Wells**15. Birthplace **Penn Pa**16 (a) Informant **Frances Leader (wife)**(b) Address **1009 S. Bouldin St.**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Aug. 3/43**

(month, day, year)

(c) Cemetery or crematory

Baltimore National

Location

North Ave. Fredk. Rd

18 (a) Funeral director

Lilly & Zeiler Inc

(b) Address

403 S. Wolfe St.

19 (a)

Aug 31 1943

(Signature of registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 31 1943 at 2 A.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Jan 3 1943** to **July 31 1943**, and that I last saw him alive on **May 18 1943**.

Immediate cause of death

adrenoleukic C.V. Deam**Cerebral Spasm**Due to **acute coronary occlusion**

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation: **none**

of autopsy

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. J. Schumacher

M. D.

Address

842 E. V. AveDate signed **7-21-43**

Duration

2 years 1941**July 21 1943**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 06820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06820

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 810 N. Gilmore Street

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM McCARGO

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Estelle Hawthorne

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1898

8. AGE: Years

45

Months

4

Days

24

If less than one day

hr.

min.

9. Birthplace Bullocks, North Carolina

(Town, county, and state)

10. Usual Occupation Trackman, P.R.R.

11. Industry or business

12. Name Brown McCargo

13. Birthplace Bullocks, N. C.

14. Maiden Name Louise I

15. Birthplace Bullocks, N. C.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof July 31, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 222 S. Enoch Ave.

19 (a) (Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1943, at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1943, to July 28, 1943, and that I last saw him alive on July 28, 1943.

Immediate cause of death Cerebral hemorrhage

Duration 5 days

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None permitted

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 7/28/43

Va-13476

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

06821

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 630 S. Fagley St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)(d) Street No. 630 S. Fagley St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John S. Wick

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-10-1912

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Margaret

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.)

Dec. 31 1899

8. AGE:

Years 43

Months 6

Days 28

If less than one day

hr. min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

Brick Mason

11. Industry or business

12. Name

John Wick

13. Birthplace

Germany

14. Maiden Name

Mary E. Clark

15. Birthplace

Balto.

16 (a) Informant

Margaret Wick

(b) Address

630 S. Fagley St.

17 (a)

Burial

(b) Date thereof 8/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Seward Heights

Location

German Hill Rd.

18 (a) Funeral director

M. W. K. Dapp's Sons

(b) Address

1405 S. Calver Ave.

19 (a)

(Date filed by registrar)

(b)

Wilmington, Delaware

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 29 1943, and that I last saw him alive on July 29 1943.

Immediate cause of death

Coronary Thrombosis

Duration

4 to 5 months

Due to

Posterior Coronary thickening several months

Due to

as shown by Electrocardiogram

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. V. Clift

Address

5010 Greenleaf Rd

Date signed

7/31/43

VS

JUL 31 1943

G 06822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06822

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~City~~ Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 912 N. Mount St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

General Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account

No. 318-123506

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Agnes Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1918

8. AGE:

Years

Months

Days

If less than one day

25

hr.

min.

9. Birthplace

Newport News Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Henry Jenkins

13. Birthplace

Va.

14. Maiden Name

Sarah Green

15. Birthplace

Va.

16 (a) Informant

Robert Jenkins

(b) Address

933 N. Mount St

17 (a)

Burial

(b) Date thereof

8/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

A. A. Co. Md.

18 (a) Funeral director

E. A. Hollander

(b) Address

927 N. Mount St.

19 (a)

Date of death

JUL 31 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1943 at 3:25 P.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Septicemia

Due to

Bullet wound of chest

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury June 18 1943 10 PM

(b) Where did injury occur? Lafayette Mar. Parish

(c) Did injury occur at home, on farm, industrial place, in public

place? public While at work? no

(d) Means of injury

Shot

23. Signature

Robert L. Graham M.D.

Date signed

July 20 1943

66823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06823

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2918 Glenmore Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-6

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2918 Glenmore Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Evelyn Woster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 - 1866

8. AGE: Years Months Days If less than one day
76 8 21 hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Smith, A. Plegato

13. Birthplace New Jersey

14. Maiden Name Elsie Weidner

15. Birthplace New York

16 (a) Informant William C. Woster

(b) Address 2918 Glenmore Ave

17 (a) Burial (b) Date thereof Aug 2 - 43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Location

18 (a) Funeral director George Schilling & Son

(b) Address 1624 Glenmont Ave

19 (a) Date rec'd by registrar 31 1943 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1943, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to 7/30 1943, and that I last saw him alive on 7/30 1943.

Immediate cause of death Cardiovascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. W. Schilling, M.D.

Address 5707 Harford Rd. Signed 7/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 619 N. Rose Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 619 N. Rose Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JOSEPH ALTMAN

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-05-8143

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or

divorced.

married

6 (b) Name of husband or wife Josephine (Svasek)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/78

8. AGE: Years

64 yrs.

Months

8

Days

15

If less than one day

hr.

min.

9. Birthplace Czechoslovakia

(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

12. Name Unknown

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant wife

(b) Address 619 N. Rose Street

17 (a) Burial (b) Date thereof 8/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Phila. Rd. Baltimore Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) 1943 (b) Registrar

1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1943 to July 29 1943, and that I last saw him alive on July 29 1943.

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny

Address 2200 E. Madison St. Date signed 7/30/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06825

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3033 Woodside Ave.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 926 N. Castle St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Josephine Macko

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

female

white

widow

6 (b) Name of husband or wife John Macko (deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1873

8. AGE:

Years

Months

Days

If less than one day

69

9

9

hr.

min.

9. Birthplace Czechoslovakia

(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name

Unknown

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

16 (a) Informant Anna Krucky-daughter

(b) Address 3033 Woodside Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof July 2, 1943

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director Charles H. Schimunek

(b) Address 2601-03 E. Madison St.

19 (a) 1943

(Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30, 1943, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 4, 1943, to July 30, 1943.

and that I last saw him alive on July 29, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph Pokorny

Address

2200 E Madison St

Date signed 7/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

copy age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06826

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
3026 Presatman Street
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days) 3 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Presatman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Alicinda Z. Wachter

3 (b) If veteran, name war

3 (c) Social Security Account
No.

Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife. Curtis Wachter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1854

8. AGE: Years 88 Months 11 Days 30 If less than one day hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Solomon Krum

13. Birthplace Frederick Co., Md.

14. Maiden Name Mary Catherine Kanode

15. Birthplace Frederick Co., Md.

16 (a) Informant Walter C. Zimmerman

(b) Address 3026 Presatman St

17 (a) Burial (b) Date thereof Oct 1 1948
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Hope
Location Spring Lake Rd

18 (a) Funeral director C. Barton

(b) Address Walkersville Rd

19 (a) Registrar

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1948 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24, 1948 to Jul. 31, 1948, and that I last saw her alive on July 30, 1948.

Immediate cause of death

Senility with exhaustion

Due to Chronic myocarditis
with hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maurice Z. Shamus

Address 3300 W. North Ave. M.D. 7/31/48

G 06827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 06827
94a Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 33rd & Calvert Street
- (c) Hospital or institution:
Union Memorial Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
- (e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:

- (a) State Minn. (b) County Minneapolis
- (c) City or town Minneapolis
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 135 W. 48th St.
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country Baltimore - residence
2702 N. Charles St.
Baltimore

3 (a) FULL NAME

MRS. CHARLES PETRAN (TABITHA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W6 (a) Single, married, widowed, or divorced.6 (b) Name of husband or wife Mr. Charles Petran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1879

8. AGE: Years Months Days If less than one day

641230hr.min.9. Birthplace Indiana

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Albert McKeehan13. Birthplace Minnesota14. Maiden Name Katharine Williams15. Birthplace Minnesota16 (a) Informant Charles Petran(b) Address 135 W. 48th St. Minneapolis17 (a) Burial (b) Date thereof Aug 2/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Minneapolis

Location

18 (a) Funeral director John C. Mitchell(b) Address 1900 East Ave. Place

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1943, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943, to July 31 1943, and that I last saw him alive on July 31 1943.

Immediate cause of death

Cardio-respiratory failure

Due to Coronary occlusion & myocardial infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature John A. Harbitt, Jr.

Address Union Memorial Hospital Date signed 7-31-43

Duration

14 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06828

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3437 Reisterstown Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3437 Reisterstown Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Max Romm

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-18-7766

4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of husband or wife

Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1865

8. AGE: Years

Months

Days

If less than one day

78

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Printing Business

FATHER
MOTHER

12. Name Jehuda L. Romm

13. Birthplace Russia

14. Maiden Name Ruth Abramson

15. Birthplace Russia

16 (a) Informant Mr Morris Dobres

(b) Address 3437 Reisterstown Road

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof August 1, 1943

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Rosedale Cem

Location

Hamilton Ave

18 (a) Funeral director

Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

AUG 1 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1943, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943, to July 30 1943, and that I last saw alive on

Immediate cause of death

CORONARY THROMBOSIS

Duration

5 min

Due to

Sen. Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. J. S. Shuler

Address 752 E. E. Pl.

Date signed 7/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

XV G 06829

Registered No.

Permanent Address - 9030 S. 5th, L. I. N. Y.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore Shipyard, Key Highway

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William H. Donnelly

3 (b) If veteran, name war

Worlds #1

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced

Married

6 (b) Name of husband or wife

Mary M. Donnelly

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

July 12 1892

8. AGE:

Years

Months

Days

If less than one day

51

hr.

min.

9. Birthplace

New York N. Y.

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Date rec'd by registrar

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-31

1943, at 9:15 A. M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial degeneration

Due to

Other Conditions Emphysema of lungs

Sec. arteriosclerosis; chronic hepatitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury

23. Signature Howard J. Morsani M.D.

Date signed 7-31-43

G 06830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06830

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Swanton Sts.*

(c) Hospital or institution:

Mary Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *-*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4912 York Rd.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Melvin Sweeten

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

July 29, 1943

8. AGE: Years Months Days

If less than one day

2

hr.

min.

9. Birthplace

Mary. Hosp. Bal. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Joseph Sweeten

13. Birthplace

Bal. Md.

14. Maiden Name

Melinda Schlick

15. Birthplace

Bal. Md.

16 (a) Informant

Deed

(b) Address

*Mary Hospital*17 (a) *Burial* (burial, cremation, or removal)(b) Date thereof *8-2-43* (month) (day) (year)

(c) Cemetery or crematory

new cathedral

Location

18 (a) Funeral director

Leonard J. Rush

Address

*5305 Stafford Road*19 (a) *AUG 1 1943* (Date rec'd by registrar)*Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 31, 1943 at 3:45 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *July 29, 1943* to *July 31, 1943*, and that I last saw *her* alive on *July 31, 1943*.

Immediate cause of death

Resp. Failure

Due to

Pneumonia (28 weeks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? *While at work?*

(Specify type of place)

(e) Means of injury

23. Signature

Leonard J. Rush

Address

*Mary Hospital*Date signed *7/31/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06831

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2846 Kentucky Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2846 Kentucky Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Catherine Gron

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Frank Gron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 12 - 1862

8. AGE:

Years

Months

Days

If less than one day

*81**6**17*

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

at Home

11. Industry or business

FATHER
MOTHER

12. Name

Andrew Neubert

13. Birthplace

Germany

14. Maiden Name

Barbara ?

15. Birthplace

Germany

16 (a) Informant

Miss Margaret Gron

(b) Address

2846 Kentucky Ave

17 (a)

Burial

(b) Date thereof

8-12-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Thelma Road

AUG 1 1943

(Date rec'd by registrar)

William H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29 1943 at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *July 1 1943* to *July 29 1943* and that I last saw him alive on *July 29 1943*

Immediate cause of death

Hypertensive

Due to

cardio

Due to

vascular

Other Conditions

Neural

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Frederick J. Williams
W. H. Williams

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06831
G 06832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 480 G 06832

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4407 Frankford Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4407 Frankford Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife J. Geo. Weiler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15 1869

8. AGE: Years 74 Months 5 Days 14
If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name James Holly

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary P.

15. Birthplace Ireland

16 (a) Informant George Weiler

(b) Address 4407 Frankford Ave.

17 (a) Burial (b) Date thereof 8-2-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Brooklyn A.C.C.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Hatfield Road

19 (a) by registration

by registration

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1943 to July 29 1943 and that I last saw her alive on July 29 1943

Immediate cause of death Myocardial Infarction

Due to Carcinoma of Cervix with metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John V. Geyserich

Address 1802 Eastern Ave Date signed 7-30-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06833

Registered

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2701 Hamilton C.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2701 Hamilton C.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Elizabeth Weiss

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W.6 (a) Single, married, widowed, or
divorced.Widow6 (b) Name of husband or wife Henry Weiss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 18538. AGE: Years Months Days
89 10 28
less than one day
hr. min.9. Birthplace Baltimore
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

12. Name

13. Birthplace Unknown

14. Maiden Name

15. Birthplace Unknown16 (a) Informant Mrs Elizabeth Weiss(b) Address 2701 Hamilton C.17 (a) Burial (b) Date thereof 8-2-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Carmel
Location18 (a) Funeral director Leonard J. Ruck(b) Address 5305 Harford Rd19 (a) 1943 (b)(Date registered) Registrar Franklin W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1943 at 8:00 A.M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 15 1943 to July 30 1943,
and that I last saw him alive on July 28 1943.

Immediate cause of death

Cerebral Embolism -Due to Generalized arteriosclerosis
Brain Atheroma -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. B. BoyleAddress 5217 Harford Rd. Date signed 7/30/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG

VS 100

G 06834

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06834

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4602 Harford Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 4315 Frankford Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Mr. E. Bungan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 1863

8. AGE: Years 79 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name David Grover

13. Birthplace

14. Maiden Name Isabelle Brown

15. Birthplace Pa.

16 (a) Informant Mrs. Nettie Hochstedt

(b) Address 4602 Harford Rd.

17 (a) Burial (b) Date thereof 8 2 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Sarah Starnes

(b) Address 7401 Belair Rd.

(c) Date of death 1 1943
(Date received by Registrar) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1943, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1943, to July 31 1943, and that I last saw her alive on July 30 1943

Immediate cause of death

Carcinoma Ovary.

Duration

1 mo.

Due to

Due to

Other Conditions Ch. Hypertension
Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. S. Starnes

Address 4810 Belair Rd. Date signed 7/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06835

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3919 BELLE AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2919 Belle Ave.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ROSE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mayer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

55

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

FATHER

12. Name

Ben Greenspan

13. Birthplace

Russia

14. Maiden Name

Not known

15. Birthplace

Russia

16 (a) Informant

Husband

(b) Address

17 (a)

Burial

(b) Date thereof

8-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Carmel

Location

German Hill Rd

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Pratt St

(a)

1943

Rose Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-1-1943 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan 2 1941 to 7/31 1943.

and that I last saw her alive on 7/31 1943.

Immediate cause of death

Acute coronary thrombosis

Due to

coronary sclerosis

Due to

Ch myocarditis

Other Conditions

Acute Pulmonary

Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

A. G. Hornstein

Address

737 Annapolis St

Date signed

8/1/43

PLEASE WRITE FULLY, WITH CARE AND INK. EVERY ITEM OF INFORMATION SHOULD BE GIVEN. DO NOT WRITE IN PENCIL. PHYSICIANS: please write the cause of death clearly and legibly.

G 06836

BALTIMORE CITY HEALTH DEPARTMENT

G 06836

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date of registration)

(b)

(Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Duration

Due to

Due to

Other Conditions

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 06837

BALTIMORE CITY HEALTH DEPARTMENT

G 06837

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *3503 Roland Ave.*
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
 (c) City or town *Balto.*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3503 Roland Ave.*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

John H. Baublitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Anna L. Baublitts*6 (c) If alive, give age *77* years7. Birth date of deceased (mo., day, yr.) *June 16, 1864*8. AGE: Years *79* Months *1* Days *14* If less than one day hr. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation *Runner, Bank*11. Industry or business *Retired*12. Name *Jeremiah Baublitts*13. Birthplace *Md.*14. Maiden Name *Jane Frank*15. Birthplace *Md.*16 (a) Informant *Anna L. Baublitts*(b) Address *3503 Roland Ave*17 (a) *Burial* (b) Date thereof *Aug 2, 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *St. Mary's*
Location *Hampden*18 (a) Funeral director *Edmund H. Danaher*(b) Address *3615-17 Chestnut Ave*(a) *1 1943* (b) *Huntington Williams, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 30, 1943* at *8:22 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *July 24, 1943* to *July 30, 1943* and that I last saw him alive on *July 29, 1943*.

Immediate cause of death

*Acute Coronary Arteriosclerosis*Due to *Coronary occlusion July 24, 1943*Due to *Arteriosclerosis of the coronary arteries*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *J. A. Fisher*Address *3615-17 Chestnut Ave* Date signed *7/30/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06838

BALTIMORE CITY HEALTH DEPARTMENT

G 06838

CERTIFICATE OF DEATH

Registered No. *47a**61 36*

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1907 Brewster Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1907 Brewster Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Henry S. Rubel

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

no

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Mary E*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov 10 - 1877*8. AGE: - Years Months Days If less than one day
65 67 8 15 hr. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation *Paper Hanger*

11. Industry or business

12. Name *Henry Rubel*13. Birthplace *Germany*14. Maiden Name *Wilmont*

15. Birthplace

16 (a) Informant *Mary E*(b) Address *1907 Brewster Ave*17 (a) *Baltimore* (b) Date thereof *Aug 2 - 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium *Walters*Location *Walters*18 (a) Funeral director *Edward Lowry*(b) Address *7059 Wash Blvd*19 (a) *1 1943* (b) Registrar *Huntington Williams, M.D.*

(Date recorded) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *7-30* 19*43* at *1 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *3/16* 19*43* to *7-30* 19*43*, and that I last saw him alive on *7-30* 19*43*.

Immediate cause of death

*Carcinoma of larynx*Duration *6 mos.*

Due to

*myocardial degeneration**3 weeks*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Patent Miller*Address *1500 N. Broadway* Date signed *7/31/43*

M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 05839

BALTIMORE CITY HEALTH DEPARTMENT

G 06839

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

Male

5 Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Katherine Broczkowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Signed and sealed by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limit, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29, 1943, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to July 29, 1943, and that I last saw him alive on July 25, 1943.

Immediate cause of death

Malignancy of left lung
Secondary adenoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PRINTED, WITH CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

G 06840

BALTIMORE CITY HEALTH DEPARTMENT

G 06840

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2511 Woodbrook Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, limited write RURAL and give town)

(d) Street No.

2511 Woodbrook Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Theodore Houseman

3 (b) If veteran, name war

3 (c) Social Security Account

No. NONE

5. Color of race

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

Sarah Houseman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 19, 1857

8. AGE:

Years

Months

Days

If less than one day

85

9

12

hr.

min.

9. Birthplace

Penna.

(Town, county, and state)

10. Usual Occupation

Shoemaker

11. Industry or business

Self

12. Name

Christina Houseman

13. Birthplace

Germany

14. Maiden Name

Elizabeth (Unknown)

15. Birthplace

Unknown

16 (a) Informant

Kerwin Houseman

(b) Address

3619 Hozwood Ave

17 (a) Burial, cremation, or removal

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Graceland

Location

North St

18 (a) Funeral director

William Evans

(b) Address

1217 St Paul St

(c) Date rec'd by registrar

August 1, 1943

(d) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31

1943 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12, 1943, to July 31, 1943.

and that I last saw him alive on July 30, 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

17 days

Due to

Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Raymond H. Culver

M. D.

Address

5616 Milford Rd

Date signed

Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

G 06841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06841

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Mon. St. + Rutland Avenue*

(c) Hospital or institution:

Simi Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *34 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County(c) City or town *Baltimore* (If outside city or town limits, give location and give town)(d) Street No. *Sylvest Apt. - Whiteblock St.* (If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Louise George

3 (b) If veteran, name war

WW

(c) Social Security Account

No. 1448

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *William*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

47 *23* *hr.* *min.*9. Birthplace *Marysville Ohio*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *William George*13. Birthplace *Ohio*14. Maiden Name *Elizabeth Carter*15. Birthplace *Ohio*16 (a) Informant *William George*(b) Address *Sylvest Apt. 1344 Md*17 (a) *Burial* (b) Date thereof *8/3/43*(c) Cemetery or crematory *London Park*Location *Baltimore*18 (a) Funeral director *William George*(b) *12/7*(c) *11943*(Date rec'd by registrar) *William George*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 31 1943 at 10:45 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *June 28 1943* to *July 31 1943*, and that I last saw her alive on *July 31 1943*.

Immediate cause of death

Malignancy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Henry M. M. M.*Address *Swan Hosp* Date signed *7-31-43*

Duration

*33 days**over*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06842
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 234 N. Stricker St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 19

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 234 N. Stricker

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1876

8. AGE: Years 67 Months - Days 13 hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Quert Steneus

13. Birthplace Virginia

14. Maiden Name Niece Paerson

15. Birthplace Virginia

16 (a) Informant Katie L. Lee

(b) Address 551 W. Darrow

17 (a) Burial (b) Date thereof Aug 1 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md.

18 (a) Funeral director Isaiah R. Brown

(b) Address 108 W. Montgomery St

19 (a) 1943 (b) by registrar

Therington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 28 1943 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to July 28 1943, and that I last saw him alive on July 28 1943

Immediate cause of death

Cerebral

Neurovascular

Due to

Hypertension

Thrombotic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dan J. [Signature]

Address 122 W. Lee Date signed 7/31/43

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06843
13-80725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G 06843
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3214 Guilford Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Raymond DEMINNIS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1880

8. AGE: Years Months Days If less than one day

62

11

6

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

12. Name John A. DEMINNIS

13. Birthplace Maryland

14. Maiden Name Amelia Warnes

15. Birthplace Maryland

16 (a) Inform BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8/3/1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Augustine

Location St. Augustine, Md.

18 (a) Funeral director John J. Brown & Son

(b) Address 2015 Hollins St.

(a) 1 1943

(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1943 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 4-2 1943 to 7-31 1943.

and that I last saw him alive on 7-31 1943.

Immediate cause of death

Carcinoma of Lung

Due to

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Webb

Address Balto City Hosp Date signed 7-31-43

Duration

4 mo.?

?

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06844

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

8 mo. 27 days.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 936 Lammon St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1886

8. AGE: Years

57

Months

2

Days

27

If less than one day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name Timothy Kennedy

13. Birthplace Md.

14. Maiden Name Emma Kelly

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof 8/2/1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address 901 E. Pratt St.

19 (a) (b)

(Date and place of registration)

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1943 at 9:10 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1943 to 7/30 1943, and that I last saw him alive on 7/30 1943.

Immediate cause of death

Pulmonary Tuberculosis

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. I. Seigman

Address B CH Date signed 7/31

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 1 1943

VS 350

Huntington Williams, M.D.

G 06845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06845
Registered No.

82943

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1506 N. Port St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Arthur Heiss

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1898

8. AGE: Years

Months

Days

If less than one day

44

9

21

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Unemp.

11. Industry or business

FATHER
MOTHER

12. Name Penfield Heiss

13. Birthplace Md.

14. Maiden Name Sarah Miller

15. Birthplace Penn.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 8-3-43 (month) (day) (year)

(c) Cemetery or crematory

Location New Freedom, Pa.

18 (a) Funeral director John C. Miller, Inc.

(b) Address 2135 E. Chesa St.

AUG 2 1943

(Date for only registered)

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1943. 1:20 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/30 1943. to 7/31 1943.
and that I last saw him alive on 7/31 1943.

Immediate cause of death

Bronchogenic Ca
C prob. cerebral metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above (not done)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. F. Serjman

Address H C H

Date signed 7/31

Duration

2 yr.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

06846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06846
Registered No.

438893

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W. Va. (b) County(c) City or town Richwood

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Larry Van Surface

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-9-36

8. AGE:

Years

Months

Days

If less than one day

7

2

22

hr.

min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Olean Surface

13. Birthplace

W. Va.

14. Maiden Name

Lulla Williams

15. Birthplace

W. Va.

16 (a) Informant

JOHNS HOPKINS HOSPITAL

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Richwood W. Va.

Location

Nicholas

18 (a) Funeral director

(b) Address

East Baltimore W. Va.

(c) Signature

(Date)

(b) Huntington Williams, M.D.

Registrar

AUG 8 1943

VS 140

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 1 1943 at 5-55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1943 to Aug 1 1943, and that I last saw him alive on Aug 1 1943

Immediate cause of death

Cardiac failure

Duration

2 weeks

Due to

rheumatic endocarditis

? 2 mos

Due to

acute rheumatic fever

3 mos

Other Conditions

aspirin hepatomegaly

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

C. E. Rourke

Address

Johns Hopkins Hosp.

Date signed

8/1/43

06847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 06847

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-09-6366A

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 2 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/30

1943 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1943 to 7/30 1943, and that I last saw him alive on 7/30 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

06848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06848
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1500 E. Pratt St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Corned6 (a) Single, married, widowed, or
divorced. 5

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 Months Days If less than one day
hr. min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual Occupation Laborer

11. Industry or business

12. Name Steven Horsey13. Birthplace md.14. Maiden Name Katie Horsey15. Birthplace md16 (a) Informant Florence Jones(b) Address 1500 E. Pratt St17 (a) Burial (b) Date thereof 8/2/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt Calvary
Location18 (a) Funeral director Elroy Wilson(b) Address 1920 Blandly Ave19 AUG 2 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1943 at 10:15 A.21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to this death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH arteriosclerotic
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.Date signed July 30, 1943

06849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06849
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1215 Urban Way
(If rural give location)(e) Citizen of foreign country? Urban (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 21 1942

8. AGE: Years Months Days If less than one day

21 16 10 hr. min.9. Birthplace Green Co Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Amos Collier13. Birthplace Va14. Maiden Name Blanch Morris15. Birthplace Va16 (a) Informant Amos Collier(b) Address 1215 Urban Way17 (a) Burial (b) Date thereof 8/3/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Collier Home Cem
Location Green Co Va18 (a) Funeral director William M. Mack19 (a) AUG 2 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1943 at 1 PM21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Crushed
chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause
death, fill in the following:(a) Date of injury July 31 1943 12 PM(b) Where did injury occur? In front of 1215 Urban Way(c) Did injury occur at home, on farm, industrial place, in public
place? street While at work? no(d) Means of injury fell under wheel of auto23. Signature Robert L. Grotzer M.D.Date signed August 1 1943 Medical Examiner

6851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06851

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3032 Brighton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3032 Brighton St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

ROBERT D. McCURDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or divorced.
married

6 (b) Name of husband or wife Katherine R. McCurdy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1868

8. AGE: Years Months Days If less than one day
75 2 14 hr. min.9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Harry T. McCurdy

13. Birthplace Pa.

14. Maiden Name Abigail Paterson

15. Birthplace Pa.

16 (a) Informant Mrs. Katherine R. McCurdy

(b) Address 3032 Brighton St.

17 (a) Burial (b) Date thereof 8/2/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

AUG 2 1943 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1943, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24, 1943 to July 29, 1943, and that I last saw him alive on July 29, 1943.

Immediate cause of death

Duration

Due to Cerebral Apoplexy
+ Hypertension6 days
4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. B. cum and Good M. D.

Address 2200 Garrison Bldg Date signed Aug 2/43

6852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06852
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Oscar L. Moon

6 (c) If alive, give age

39 years

7. Birth date of deceased (mo., day, yr.)

Dec. 1, 1910

8. AGE:

Years

Months

Days

If less than one day

32

7

29

hr.

min.

9. Birthplace

Frederick, Md.

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

at home

FATHER
MOTHER

12. Name

Nelson J. Lockman

13. Birthplace

Frederick, Md.

14. Maiden Name

Daisy Darr

15. Birthplace

Frederick, Md.

16 (a) Informant

Oscar L. Moon (Husband)

(b) Address

4105 Townsend Ave.

17 (a)

Burial

(b) Date thereof

Aug. 2, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Beverly Hill Cem.

Location

A. Q. Co., Md.

18 (a) Funeral director

A. Howard Evans

(b) Address

1400 S. Charles St.

AUG 2 1943

(b) Huntington Williams, Jr.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4105 Townsend Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30, 1943 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan 2 1941 to July 30 1943

and that I last saw him alive on July 30 1943

Immediate cause of death

Myocardial insufficiency

Duration

2 wks

Due to

Advanced pulmonary TB

Due to

3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John V. Seubert

Address

1802 Eastern Ave.

Date signed 7-31-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

06853

HEALTH DEPARTMENT—CITY OF BALTIMORE

06853

CERTIFICATE OF DEATH 107

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. FRANKLIN SQUARE Hospital)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city of town where death occurred yrs mos. da. How long in U.S. if of foreign birth? yrs mos. da.

2. FULL NAME

DONNA J. BURTON(a) Residence: No. 1607 W. JAYETTE

(Usual place of abode)

St.,

Ward.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. Color or Race

White

5. Single, Married, Widowed, or Divorced (write the word)

S.

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year)

NOV 28 - 1942

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0843

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

BALTIMORE
MARYLAND

MOTHER FATHER

13. NAME

DARRELL M. BURTON

14. BIRTHPLACE (city or town) (State or country)

PORTSMOUTH
OHIO

15. MAIDEN NAME

BONNIE J. MINNERIA

16. BIRTHPLACE (city or town) (State or country)

PORTSMOUTH
OHIO

17. INFORMANT

DOLLY M. GRIM

(Address)

21 N. STEICKER ST

18. BURIAL, CREMATION, OR REMOVAL

PORTSMOUTH, OHIO Date AUG 2 1943

19. UNDERTAKER

(Address)

R. C. + B. M. WALKERPLATT & Spraker Sts.20. AUG 2 1943Washington Williams, M.D.

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 2 1943

22. I HEREBY CERTIFY, That I attended deceased from

8-1

1943, to

8-1

1943

I last saw him alive on

19

Death is said

to have occurred on the date stated above, at 8:30 PM

The principal cause of death and related causes of importance were as follows:

Pneumonia - broncho

Date of onset

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

H. P. Friedman M. D.
1319 Light StApproved by Howard J. Mackay, M.D.

OCCUPATION is very important. See instructions on back of certificate.

G 06854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06854
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calver & Saratoga*

(c) Hospital or institution:

Mercy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *12*(e) Length of stay in Baltimore (yrs., mos., or days) *38*

2. USUAL RESIDENCE OF DECEASED:

(a) *Same Maryland* (b) County *Baltimore*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2138 Guilford Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Daniel D. Welch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Yvonne Lillian Welch*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 30, 1940*

8. AGE: Years Months Days If less than one day

*62**8**-**hr.**min.*

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Legat. Business

11. Industry or business

Himself

12. Name

John Welch

13. Birthplace

Maryland

14. Maiden Name

Mary

15. Birthplace

Maryland

16 (a) Informant

Lillian Welch

(b) Address

*2138 Guilford Ave*17 (a) *Burial*

(b) Date then

Aug 3-4

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Rood

Location

Calver & Saratoga

18 (a) Funeral director

John D. McLean

(b) Address

*4701 Greenmount*19 *AUG 2 1943**Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 30 1943 at 5:00 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *July 21 1943* to *July 30 1943*, and that I last saw *him* alive on *July 30 1943*

Immediate cause of death

Respiratory failure

Due to

Due to

Other Conditions

Transurethral Prostatectomy

(Include pregnancy within 3 months of death)

Date of operation *July 29 1943*Major findings of operation *Benign Hypertrophied Prostate Gland*

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

*at**M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. R. Briggs

M. D.

Address

*Mercy Hospital*Date signed *7/30/43*

06855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

06855

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Smith Baltimore Genl Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 204.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~St. Paul~~ (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1847 Covington Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert (Ooley Gene) Candill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 24, 1934

8. AGE:

Years

Months

Days

If less than one day

8

10

7

hr.

min.

9. Birthplace

Portsmouth Ohio

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Arthur A. Candill

13. Birthplace

Portsmouth Ohio

14. Maiden Name

Mary E. McLaughlin

15. Birthplace

Huntington Kentucky

16 (a) Informant

Mrs. Arthur Candill

(b) Address

1847 Covington Ave.

17 (a)

removal

(b) Date thereof

Aug 2/43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Lynne Funeral Home

Location

Portsmouth Ohio

18 (a) Funeral director

Fred A. Krause & Son

(b) Address

216 S. Charles St.

19 (a)

AUG 2 1943

(b) Registrar

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31

1941, at 11 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

July 31 1943 11:40 AM

(b) Where did injury occur?

Charles St near Cross St.

(c) Did injury occur at home, on farm, industrial place, in public

place? street

While at work? No

(d) Means of injury

Child ran in front of auto

23. Signature

Robert L. Williams, M.D.

Date signed

July 31 1943

06856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93a Registered 06856

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 432 S. Patterson Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

704 S. Durham St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Lorraine

A. Lentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22-1942

8. AGE:

Years

Months

Days

If less than one day

—

11

9

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Adam Lentz

13. Birthplace

Baltimore Md.

14. Maiden Name

Virginia WYATT

15. Birthplace

Baltimore Md.

16 (a) Informant

Mrs Virginia LENTZ

(b) Address

704 S. Durham St

17 (a)

Burial

(b) Date thereof

8-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Rosary

Location

Baltimore Co. Md.

18 (a) Funeral director

George A. Weber

(b) Address

704 S. Ann. St

19

Aug 2 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31 1943, at 7 PM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Dilatation

of heart, acute

Due to

Acute myocarditis (Fiedler's myocarditis)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Graham

M.D.

Date signed

August 1 1943

06857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06857
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Barnard Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1412 N. Mount Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME Bertrude Brown

3 (b) If veteran, name war

3 (c) Social Security Account
No. Two

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 15, 18788. AGE: Years Months Days If less than one day
65 1 15 hr. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

David Randall

13. Birthplace

Md.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

"16 (a) Informant Mammy Smith(b) Address 1412 N. Mount Street17 (a) Burial (b) Date thereof 8-4-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt Auburn

Location

md18 (a) Funeral director George S. Nelson(b) Address 1303 Prestonman St19 AUG 2 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-1943 at 8³⁰ P.M.21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of Heart (Transverse)

Due to

Other Conditions Multiple stab wounds

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 7-30-43 at 7:30 P.M.(b) Where did injury occur? 1412 N. Mount Street(c) Did injury occur at home, on farm, industrial place, in public
place? Home While at work? No(d) Means of injury Sharp instrument23. Signature Thomas J. Mulderis M.D.Date signed 7-31-43

Medical Examiner

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06858

Registered No. 159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph Baby Boy Nowak JR

3 (b) If veteran, name war

3 (c) Social Security account

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 1-43

8. AGE: Years

Months

Days

If less than one day

10 hr. min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Joseph Nowak

13. Birthplace

Balto., Md.

MOTHER

14. Maiden Name

Rose Siwach

15. Birthplace

Balto., Md.

16 (a) Informant

Joseph Nowak

(b) Address

3215 O'Donnell St

17 (a)

Burial

(b) Date thereof

8-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

18 (a) Funeral director

Wm. S. Fialkowski

(b) Address

2007 Eastern Ave

19

AUG 2 1943

(b) Huntington Williams St.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3213 O'Donnell St.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-1-

1943 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1943 to 8-1 1943

and that I last saw him alive on 8-1 1943.

Immediate cause of death

Prematurity

Due to

Premature separation of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles P. Mayhew

Address

1213 Light St

Date signed 8-1-43

M. D.

Please print or type in ink. If space is insufficient, attach separate sheet. Physicians: please write the causes of death clearly and legibly.

06859

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

Registered No.

G 06859

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town Spotsylvania

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Richard Mason Waller

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct. 5, 1872

8. AGE: Years Months Days If less than one day

70

9

27

hr.

min.

9. Birthplace

Spotsylvania Va

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name Alvin B. Waller

13. Birthplace Spotsylvania Va

14. Maiden Name Minerva Sticks

15. Birthplace Va

16 (a) Informant Mrs. Sime T. Lewis

(b) Address Avenue Mills Va

17 (a) Burial Date thereof 8/6/43

(burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Spotsylvania

Location Spotsylvania, Va.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address North & Penna. Aves.

19 AUG 2 1943

(b) Frankston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-1943, at 3:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-Respiratory Failure

Due to Hypostatic Pneumonia

Other Conditions Fractured 4 & 5 Thoracic Vertebrae

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-4-43 at 4 A.M.

(b) Where did injury occur? Spotsylvania, Va

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fell from porch

23. Signature Howard J. Morrison

M.D.

Date signed 8-2-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 06860
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Greenpring & Belvedere Ave.*
(c) Hospital or institution: *Hebrew Home for Aged & Infirm*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 1/2 yrs.*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *Greenpring & Belvedere Ave.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mollie Rosenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12 78

8. AGE:

Years

Months

Days

If less than one day

65

3 hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name

Mollie

13. Birthplace

Russia

14. Maiden Name

Sarah

15. Birthplace

Russia

16 (a) Informant

Aged Home

(b) Address

17 (a)

Burial

(b) Date thereof

8-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Harriet's Run

Location

Phil Ad & Brothers Inc.

18 (a) Funeral director

1439 E. Pratt St.

(b) Address

19

AUG 2 1944

Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-2-

19*43*, at *12:30* P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *2/23/1940* to *8/1/1943*, and that I last saw her alive on *8/1/1943*.

Immediate cause of death

*Ch. card. vascular disease.
Ch. nephritis.*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Edmund Leary

Address

Levinthal

Date signed

8/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

06861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06861

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland.

(b) Street address

Sinai Hospital

(c) Hospital or institution:

Monument St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

27 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3602 Oakmont Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

SOLOMON KAUFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Hettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

71

hr.

min.

9. Birthplace

Rising

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Not Known

13. Birthplace

Rising

14. Maiden Name

Not Known

15. Birthplace

Rising

16 (a) Informant

Hettie Kaufman

(b) Address

17 (a)

Burial

(b) Date thereof

8-3-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Helen's Cemetery

Location

Phil & Conklin Sts.

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1438 E. Baltimore St.

AUG 2 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 2, 1943, at 7:20 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 2, 1943, to AUG 2, 1943, and that I last saw him alive on AUG 2, 1943.

Immediate cause of death

CARDIAC FAILURE

Due to

ARTERIOSCLEROTIC CVD.

Due to

Other Conditions

PULMONARY EDEMA

+ PRE-OP PROSTATECTOMY

(Include pregnancy within 3 months of death)

Date of operation

JULY 6, 1943

Major findings of operation:

BENIGN PROSTATIC HYPERTROPHY

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Jung Robert Long

Address

Sinai Hospital

Date signed 8/2/43

G 06862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46BG 06862
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Jayeth Pulaski*

(c) Hospital or institution:

Wan Secours Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Mrs. Agnes Smyser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mrs. William Smyser

6 (c) If alive, give age years

7. Birth date of deceased mo., day, year

July 26 1895

8. AGE: Year Months Days

*48**5**15*

If less than one day

9. Birthplace

Baltimore Md

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Dr. B. Morlarty

13. Birthplace

Virginia

14. Maiden Name

Amelia H. Smyser

15. Birthplace

Wilmington, DE

16 (a) Informant

Am H. Smyser

(b) Address

1957 H Jayeth St

17 (a)

Burial

(b) Date thereof 8-3-43

(c) Cemetery or crematory

Waltham

Location

Baltimore Md

18 (a) Funeral director

James A. Taylor

(b) Address

Jayeth & Jayeth

19 (a)

Aug 4 1943

(Date recorded by Registrar)

Huntington Hill

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limit, write RURAL and give town)

(d) Street No.

1957 H Jayeth St

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 31 1943 at 10 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 6/2/1993 to 7/31/1973

and that I last saw him alive on

Immediate cause of death *Carcinoma*Due to *Generalized Carcinoma*Due to *Ductal Ca*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature *Charles P. Conroy*

Address

Date signed

M. D.

G 06863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06863

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

Baltimore

(d) Street No. 1641 Cliftview Ave.

(e) Citizen of foreign country? (Yes or No)

If rural give location

If yes, name country

3 (a) FULL NAME

Agnes Roberts or Holmes

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-08-0231

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

I

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25 1895

8. AGE: Years Months Days If less than one day

47 11 5 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Tailor Shop

12. Name Frank Jankiewicz

13. Birthplace Germany

14. Maiden Name Catherine Dekowski

15. Birthplace Poland

16 (a) Informant Banny S. Roberts (Son)

(b) Address 1641 Cliftview Ave

17 (a) Burial (b) Date thereof Aug. 3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary Church

Location German Hill Rd. Baltimore Md.

18 (a) Funeral director Frank Della Nore

(b) Address 52 N. Morley St.

Date of death 2 1943

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-1943 at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1943 to 7-30 1943, and that I last saw him alive on 7-30 1943.

Immediate cause of death

Non Specific Encephalitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Autopsy performed by Dr. Jankiewicz

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Kijanowski

Address St. Joseph's Hosp. Date signed 7-30-43

Duration

52 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06864

FORSH
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06864
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 2 - 1943

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943. 7/31 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1943 to 7/31 1943 and that I last saw him alive on 7/31 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

7/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06865

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06865
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1673 Darley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1673 Darley Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Henry P. Bitzel

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorcedMARRIED6 (b) Name of husband or wife HILDA BITZEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 13-19018. AGE: Years Months Days If less than one day
42 1 20 19 hr. min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual Occupation RAILROAD MAIL

11. Industry or business

12. Name PHILIP P. BITZEL13. Birthplace MD14. Maiden Name BARBARA REUTNER15. Birthplace MD16 (a) Informant HILDA BITZEL(b) Address 1673 DARLEY AVE17 (a) BURIAL (b) Date thereof AUG-4-1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery BALTIMORE CEM.Location BALTO. MD.18 (a) Funeral director MRS. CLAS. A. G. ROHDE(b) Address 2327 EDMONDSON AVE.19 AUG 2-1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1943 at 2:45 AM21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Hugh B. McCallisterDate signed 8/2/43 Medical Examiner.

G 06866

MJ-82509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06866

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs., 5 mos., 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(f) Street No. 1744 Harford Ave.

(If rural give location)

(g) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Holthouse

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leonora M. Tyrell

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1861

8. AGE: Years 82 Months 6 Days 29 If less than one day hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Unemployed 15 yrs.

11. Industry or business Supported by son

12. Name Frederick Holthouse (D)

13. Birthplace Holland

14. Maiden Name Mary Von Emblden (D)

15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8/3/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loyden Park

Location Frederick Rd. Balt. Md.

18 (a) Funeral director George J. Ruth Inc.

(b) Address 1735 Harford Ave.

19 (a) Date 2/19/43 (b) Registrar

(Date rec'd by registrar) AUG 2 1943 Registrar

J. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1943 at 9:00 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/30 1943.

and that I last saw him alive on 7/31 1943.

Immediate cause of death Coronary failure

Due to arteriosclerotic C.V. disease

Due to arteriosclerotic C.V. disease

Other Conditions arteriosclerotic C.V. disease

(Include pregnancy within 3 months of death)

Date of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Jan. 30, 1943 at M

(c) Where did injury occur? Baltimore, Md.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home in yard While at work? No.

(Specify type of place)

(e) Means of injury Fall down in his yard.

23. Signature E. J. Serghian

Address R C H.

Date signed 7/31

Duration

2 hr.

?

?

?

?

?

?

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

06867
76900BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30706867
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos., 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1415 N. Central Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emma Newman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Weston Newman (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1874

8. AGE: Years Months Days If less than one day

69

2

27

hr.

min.

9. Birthplace West Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Reed (D)

13. Birthplace West Virginia

MOTHER

14. Maiden Name Julia ? (D)

15. Birthplace West Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8 3 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt Calvary & Co

Location A. A. Co

18 (a) Funeral director Palmer Sanders

(b) Address 412 E. Preston St

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

(Date rec'd by registrar)

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1943 at 1:40 A

21. I certify that death occurred on the date above stated; that I attended
deceased from 7/1 1943 to 7/30 1943

and that I last saw him alive on 7/30 1943.

Immediate cause of death Cardiac

failure, acute

Due to Syphilis C-C

disease & aortic

insufficiency

Due to

Other Conditions Gen. arterio-

sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Serjman

Address 10 CH

Date signed 7/31/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06868

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1063 W. Lexington St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)(d) Street No. 1063 W. Lexington St
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Selia Lunn

3 (b) If veteran, name war

3 (c) Social Security Account
No. 999

4. Sex

Female

5. Color or race

Colored6 (a) Single, married, widowed, or
divorcedWidow6 (b) Name of husband or wife Robert Lunn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1887

8. AGE:

56

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace Darlington S. C.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Calvert M. Clendon

13. Birthplace

Darlington S. C.

14. Maiden Name

King

15. Birthplace

Darlington S. C.

16 (a) Informant

Selia Lunn, widow

(b) Address

1063 W. Lexington St17 (a) Shipped

(Burial, cremation, or removal)

(b) Date thereof Aug 2, 43
(month, day, year)

(c) Cemetery or crematory

Darlington

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Schroeder St19 2-1943

(Signed by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1943 at 7:20 PM21. I certify that death occurred on the date above stated that I attend-
ed deceased from July 23, 1943 to July 30, 1943
and that I last saw her alive on July 30, 1943

Immediate cause of death

Cerebral Hemorrhage

Due to

Hypertension

Due to

Hard Arteries

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

M. D. WilliamsAddress 803 N. Frederick M. D. 8-2-43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06869

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

406 N. Carrollton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balto.

(d) Street No.

406 N. Carrollton Ave

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert L. Brantly

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 5/1943

8. AGE:

Years

Months

Days

If less than one day

2

25

hr.

min.

9. Birthplace

Marman, b. c.

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

12. Name

David Brantly

13. Birthplace

b. c.

14. Maiden Name

Eva Mae Shannon

15. Birthplace

b. c.

16 (a) Informant

Eva Mae Brantly

(b) Address

406 N. Carrollton Ave

17 (a) Burial

(b) Date thereof

Aug 2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Zion Cem

Location

18 (a) Funeral director

Mrs Kate R. Williams

(b) Address

322 N. Carrollton St.

19 (a) (b) Registrar

Huntington Williams, M.D.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30

1993, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1993, to July 30 1993, and that I last saw him alive on July 30 1993.

Immediate cause of death

Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. E. Exchange

Address

805 N. Carrollton St.

G 06870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06870

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1002 Riverside Ave.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1002 Riverside Ave.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Ella Louise Thomas

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1868

8. AGE: Years Months Days If less than one day
75 1 29 hr. min.

9. Birthplace Dorchester County, Md.

(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Thomas Thomas

13. Birthplace Dorchester County, Md.

14. Maiden Name Margaret A. Thomas

15. Birthplace Dorchester County, Md.

16 (a) Informant Milton F. Thomas

(b) Address 1002 Riverside Ave.

17 (a) Buried (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Location Cambridge, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.

(b) Address 1908 Eutaw Place

19 (a) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1943 at 10:25 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from April 19 1938 to Aug 2 1943.
and that I last saw him alive on Aug 2 1943.

Immediate cause of death

Carcinoma of Right
Thyroid

Due to

Due to

Other Conditions Generalized
Carcinomatosis - Cachexia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Vincent M. Messina M. D.

Address 1403 S. Charles St. Date signed

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 2 1943

G 06871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06871

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

N. CAROLINE ST.

(c) Hospital or institution:

ST JOSEPH'S HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7 DYS

(e) Length of stay in Baltimore (yrs., mos., or days)

LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2308 ARLINGTON AV

(e) Citizen of foreign country?

(If rural, give location)

NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

FRANCIS JOSEPH CASSIDY

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 212-05-6250

4. Sex

MALE

5. Color or race

W

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

FRIEDA CASSIDY

6 (c) If alive, give age

49 years

7. Birth date of deceased (mo., day, yr.)

NOV 27-1889

8. AGE:

Years

Months

Days

If less than one day

53

8

4

hr.

min.

9. Birthplace

BALTIMORE

(Town, county, and state)

10. Usual Occupation

CHEVYER

11. Industry or business

GAS COMPANY

FATHER
MOTHER

12. Name

THOS CASSIDY

13. Birthplace

BALTIMORE

14. Maiden Name

CATHERINE WELSH

15. Birthplace

BALTIMORE

16 (a) Informant

HOSPITAL RECORDS

(b) Address

ST JOSEPH'S HOSPITAL

17 (a)

BURIAL

(b) Date thereof

8/3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

ST. REDFERN

Location

DELAIR ROAD

18 (a) Funeral director

CHAS. F. EVANS-SUN

(b) Address

118 W MT ROYAL AVE

19 (a)

8-19-43

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-31

1943, at 8:58 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1943, to 7-31 1943, and that I last saw him alive on 7-31-1943.

Immediate cause of death

Acute Dilatation of Stomach

Due to

Imbibing of a pitcher of water. Following operation

Due to

an perforated peptic ulcer.

Other Conditions

Terminal Pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)

Date of operation

7/24/43

Major findings of operation:

Perforated

Stomach Ulcer.

If autopsy

Dilatation Stomach Bilateral

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

William J. Murphy

Address

St. Joseph's Hospital signed 8/1/43

G 06872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06872

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Dec 28, 1942

(e) Length of stay in Baltimore (yrs., mos., or days) Since Dec 28, 1942

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Anne Arundel

(c) City or town Annapolis

(If outside city or town limits, write RURAL and give town)

(d) Street No. 43 Larkin Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME FREDERICK JOHNSON

3 (b) If veteran, name war

World's War

3 (c) Social Security Account No.

4. Sex Male

5. Color or race

XXXX

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Louise Brown

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr) Dec. 11, 1892

8. AGE: Years Months Days If less than one day

50

7

22 21

hr.

min.

9. Birthplace Annapolis, Md.

(Town, county, and state)

10. Usual Occupation Cook, Naval Hospital

11. Industry or business Cook, Naval Hosp., Annapolis

12. Name Louis L. Johnson

13. Birthplace Annapolis, Md.

14. Maiden Name ? Sharps

15. Birthplace Annapolis, Md.

16 (a) Informant Records, U.S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 8-5-43 (month) (day) (year)

(c) Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18 (a) Funeral director Stephen L. Hicks

(b) Address 45 Northwest St.

AUG 27 1943

(Huntington Williams, Jr.)

VB 180

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 2, 1943, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28, 1943, to Aug. 2, 1943, and that I last saw him alive on Aug. 2, 1943.

Immediate cause of death Carcinoma of prostate, with multiple metastases

Duration

18 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Orchiectomy

bilateral Major findings of operation: Carcinoma

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/2/43

Va-12532

Gones

G 06873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06873

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison St. & Linden Ave*

(c) Hospital or institution:

Maryland General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *15 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Eliza Broddus Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Elva*6 (c) If alive, give age *32* years7. Birth date of deceased (mo., day, yr.) *March 12, 1900*8. AGE: Years Months Days If less than one day
43 7 21 hr. min.9. Birthplace *Albemarle County, Va.*
(Town, county, and state)10. Usual Occupation *Plumber*11. Industry or business *Beth-Steel Co.*12. Name *Eliza Broddus Hughes*13. Birthplace *Virginia*14. Maiden Name *Bertie Bludky*15. Birthplace *Albemarle County, Va.*16 (a) Informant *Mr. Roy Hughes*(b) Address *Hawthorne Rd. Plantersville, Va.*17 (a) *removal* (b) Date thereof *8/2/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location *Manassas, Va.*18 (a) Funeral director *Saschi's Funeral Home*(b) Address *Hyattsville Md.*19 (a) *1343* (b) *Huntington Williams, Jr.*
VB 150 Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Va.*(b) County *Prince William*(c) City or town *Manassas*

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? *No*

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/2* 19*43*, at *5:30* AM21. I certify that death occurred on the date above stated; that I attended deceased from *8/1* 19*43* to *8/2* 19*43*, and that I last saw him alive on *8/2* 19*43*.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions *Chronic myocarditis**& auricular fibrillation*

(Include pregnancy within 3 months of death)

Date of operation *None*

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work?

(e) Means of injury

23. Signature *John D. King, Jr.*Address *Md. Gov. House* Date signed *8/2/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06874

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address 2307 Elsinor Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2307 Elsinor Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Nancy C. O'Connell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Daniel J. O'Connell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1864

8. AGE:

Years

Months

Days

If less than one day

79

1

10

hr.

min.

9. Birthplace Hanover, Pa.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name Jacob M. Kaufman

13. Birthplace Hanover, Pa.

14. Maiden Name Louisa

15. Birthplace Hanover, Pa.

16 (a) Informant Mrs. Charles M. Clark

(b) Address 2307 Elsinor Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug. 3, 1943

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director E. W. Lamon

(b) Address 4510 Liberty Heights Ave.

19 (a) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1943, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943, to Aug 1 1943, and that I last saw him alive on Aug 1 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles L. Heston

Address 1730 Linden Ave. Date signed 7/2/43

Duration

6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and accurately.

G 06875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06875

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4900 Haddon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar)

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

April 43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly.

AUG 1943

G 06876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06876

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital, Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 554 Presstman St (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roney Tolar

3 (b) If veteran, name war

3 (c) Social Security Account
No. 216-16-3117

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 36 Months Days If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Fairfield Shipyard

12. Name Everett Tolar

13. Birthplace N. C.

14. Maiden Name Julia Gray

15. Birthplace N. C.

16 (a) Informant Vondlger Tolar

(b) Address 1805 Etting St

17 (a) Burial (b) Date thereof 8/2/43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Location Anne Arundel Co. Md.

18 (a) Funeral director Adolphus Kalstad

Address 918 Druid Hill Ave.

AUG 2 1943 (Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 1943 at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1943, to 7-28 1943 and that I last saw him alive on 7-28 1943.

Immediate cause of death Asphyxia + Respiratory failure

Due to Bilateral Lobar pneumonia

Due to 4 pneumonia

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Julius St. White

Address Provident Hosp. Baltimore, Md.

Date signed 7-31-43

Duration 2 hrs 48 min

PHYSICIAN

Underline the cause to which death should be charged statistically.

06877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06877
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive and 31st S.
- (c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State India (b) County
- (c) City or town Calcutta
(If outside city or town limits, write RURAL and give town)
- (d) Street No.
- (e) Citizen of foreign country? (Yes or No)
If yes, name country India

3 (a) FULL NAME

SAHID ALI

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Indian

6 (a) Single, married, widowed, or divorced.
Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

1910

8. AGE:

33

Years

Months

Days

hr.

min.

9. Birthplace

Syllich East India
(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

MOTHER FATHER

12. Name

Hyaj Mohamed

13. Birthplace

Syllich East India

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Records-US Marine Hospital

(b) Address

Baltimore, Md.

17 (a)

Burial

(b) Date thereof

8/2/43

(c) Cemetery or crematory

Lorraine

Location

Mt. Vernon

18 (a) Funeral director

William Williams, Inc.

(b) Address

1217 1st St. S.

AUG 8 - 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1943, 8:55p.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1943, to July 30, 1943, and that I last saw him alive on July 30, 1943.

Immediate cause of death

Bilateral lobar pneumonia

Generalized peritonitis

Due to Adenocarcinoma of jejunum multiple with perforation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/29/43

Major findings of operation: Exp. lap.

Resection tumor of jejunum side to side anastomosis of jejunum; appendectomy of autopsy: NONE

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Williams

Address US Marine Hospital

Date signed 8/31/43

Baltimore, Maryland

Duration

24 hr.

72 hr.

Unknown

PHYSICIAN

Underline the cause to which death should be attributed.

5878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06878
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2415 E. Biddle St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

60 years

3 (a) FULL NAME

Henry Hoffmann

3 (b) If veteran, name war

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Dora Hoffmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 15, 1875

8. AGE:

Years

Months

Days

If less than one day

68

6

16

hr.

min.

9. Birthplace

Germany

10. Usual Occupation

Carpenter

11. Industry or business

Hoffman Bros. Co.

FATHER

12. Name

George Hoffmann

13. Birthplace

Germany

MOTHER

14. Maiden Name

Dorothea Eisehrader

15. Birthplace

Germany

16 (a) Informant

Madeline E. Hoffmann

(b) Address

2415 E. Biddle St.

17 (a)

Burial

(b) Date thereof

8/4/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

A. A. Co. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

AUG 3 - 1943

William Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto

(d) Street No.

2415 E. Biddle St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 1st 1943, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943, to August 1, 1943, and that I last saw him alive on Aug 1, 1943.

Immediate cause of death

Coronary thrombosis

Due to

Ch. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William Williams, M.D.

Address

801 N. Kenwood Ave

Date signed

8/2/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06879
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1625 Hanover St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Philip C. Lulie

3 (b) If veteran, name war

3 (c) Social Security Account No. *none*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Ella Lulie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 24th 1920

8. AGE:

Years

Months

Days

If less than one day

*22**8**8*

hr.

min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

Student

11. Industry or business

FATHER
MOTHER12. Name *John Philip Lulie*

13. Birthplace

Md.

14. Maiden Name

Ella Mavers

15. Birthplace

Md.

16 (a) Informant

John P. Lulie

(b) Address

1625 Hanover St.

17 (a)

Burial

(b) Date thereof

8/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Parkwood

Location

Parkville, Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 S. Paul St

19 (a)

Huntington Williams, M.D.

Date signed by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1625 Hanover St*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 2nd 1943* *2³⁰ P. M*21. I certify that death occurred on the date above stated; that I attended deceased from *July 12 1943* *Aug 1 1943* and that I last saw him alive on *Aug 1 1943*

Immediate cause of death

Bronchopneumonia (Bilateral)

Duration

20 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. S. Williams

Address

*436 E Fort Ave*Date signed *8/2/43*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108 ✓ Registered No. 6880

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Rose E. Baker

3 (b) If veteran, name war

D

3 (c) Social Security Account
No. N/A

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced Widowed

6 (b) Name of husband or wife Irvin Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Aug 19th 1891

8. AGE: Years Months Days If less than one day

50

11

12

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

John Krugel

13. Birthplace

Germany

MOTHER

14. Maiden Name

Margaret White

15. Birthplace

Germany

16 (a) Informant Mrs Charles Baker

(b) Address 4001 Willsby St.

17 (a) Burial (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Balto.

Location

Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 AUG 3 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2243 Kirk Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1943, at 4¹⁰ AM21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Lobar

pneumonia, right upper &
middle lobes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert E. Graham M.D.

Date signed

August 1 1943.

06881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06881
Registered No.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 1704 De Soto Road
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1704 De Soto Road
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Francis Quinn
 3 (b) If veteran, name war ✓ 3 (c) Social Security Account No. in

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced single
 6 (b) Name of husband or wife Emma P. Quinn
 6 (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov. 13 - 1871
 8. AGE: Years 71 Months 8 Days 18 If less than one day hr. min.

9. Birthplace Balto. Md.
 (Town, county, and state)

10. Usual Occupation Retired
 11. Industry or business Ice cutter

12. Name Francis Quinn
 13. Birthplace Balto. Md.
 14. Maiden Name Ellen Gordon
 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Howard Small
 (b) Address 1704 De Soto Rd

17 (a) Burial (b) Date thereof 8/4/43
 (Burial, cremation, or inquest) (month) (day) (year)
 (c) Cemetery or crematory Cathedral
 Location Balto. Md.

18 (a) Funeral director William Cook Inc.
 (b) Address 1217 St. Paul St.

19 AUG 8 - 1943 (Date rec'd by registrar) Hamilton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1-1943 at 2:00 PM

21. I certify that I took charge of the remains described above, held an Autopsy - Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were
 IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to
 Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ M.
 (b) Where did injury occur?
 (c) Did injury occur at home, on farm, industrial place, in public place? While at work?
 (d) Means of injury

23. Signature Howard J. Walderis M.D.
 Date signed 8-2-43 Medical Examiner.

06882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 05882
Registered

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery

Location

18 (a) Funeral director

(b) Address

19 AUG 8 1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1128 E. North Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1/43 19 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1943 to 8/1 1943.

and that I last saw him alive on 8/1 1943.

Immediate cause of death Respiratory failure

Cachexia

Due to

Due to Ca. of Stomach

Other Conditions

(Include pregnancy within month of death)

Date of operation 6/3/43

Major findings of operations: Stomach & Metastasis

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address Mercy Hosp. Date signed 8/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered in correct age is especially important. Physicians: please write the causes of death clearly and legibly

06883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 06883
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution

South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

3 (a) FULL NAME

Robert Butler Gibson

3 (b) If veteran, name war

M

3 (c) Social Security Account

No 212-03-2965

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Clara Estella Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1885

8. AGE: Years Months Days If less than one day

57

10

28

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Credit Manager

11. Industry or business

Pilot Shoe Co.

12. Name

George Gibson

13. Birthplace

Md.

14. Maiden Name

Agnes

15. Birthplace

Unknown

16 (a) Informant

Mrs Clara E. Gibson

(b) Address

3125 Gaymans Falls Pkwy

17 (a) Burial (b) Date thereof 8/3/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Balto.

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

19 (a) Date rec'd by registrar

AUG 9 - 1943

27 St. Paul St

(b) Hunterdon Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3125

Gaymans Falls Pkwy

(e) Citizen of foreign country?

yes.

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1943 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1943 to 7-31 1943

and that I last saw him alive on 7-31 1943

Immediate cause of death Hypertensive
cardio-vascular disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Charles B. McDonald

Address 1213 Light St

Date signed 7-31/43

PLEASE WRITE PLAINLY, WITH CARE. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 06884

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06884
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 856 Park Ave
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

3 (a) FULL NAME

George W. Freaner

3 (b) If veteran, name war

✓3 (c) Social Security Account
No. ✓ No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Rosa Smither

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

1/5/1865

8. AGE:

Years

Months

Days

If less than one day

78626

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

Antique Dealer

11. Industry or business

✓FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Geo. G. Freaner

(b) Address

418 Birmingham Road

17 (a)

Burial (b) Date thereof Aug 4/48
(Burial, cremation, or removal) (month, day, year)

(c) Cemetery or repository

Location

David Ridge
Pikesville, Md.

18 (a) Funeral director

John O. Mitchell

(b) Address

1900 Easton Place

19 (a)

AUG 3-1948
(Date of registration)Huntington Williams
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 856 Park Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-1-1948, at 9:30 M21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

Signature Howard J. Walcott

M.D.

Date signed 8-2-48

Medical Examiner.

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

06885

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31

1943

at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1943, to July 31 1943, and that I last saw him alive on July 31 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFOLDING INK. Every fact of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 3-1943

G 06886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06886
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1629 CLIFTVIEW AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1629 CLIFTVIEW AVE

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN THOMAS MOSHER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife LOUISA MOSHER

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Nov 4 - 1865

8. AGE: Years Months Days If less than one day

77

8

28

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Motor Vehicle Repair

11. Industry or business

12. Name

John Mosher

13. Birthplace

Md

14. Maiden Name

Dora Burr

15. Birthplace

Md

16 (a) Informant LOUISA MOSHER

(b) Address 1629 Cliftview Ave

17 (a) Burial (b) Date thereof Aug 5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) AUG 3 - 1943

(Date of registration)

Huntington William 501 N. Luzerne Ave Date signed 8/2/43

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1943 at 7: AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Aug 2 1943, and that I last saw him alive on August 1, 1943.

Immediate cause of death

Complete Heart Block

Due to Arterio-Sclerotic
CARDIO-VASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Benjamin H. Jones Jr.
M.D. 501 N. Luzerne Ave Date signed 8/2/43

Duration

7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *94a*

G 06887

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address *503 S. Savage St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William Ward Raynor

3 (b) If veteran, name war

3 (c) Social Security Account

No. *213-10-0070*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Marguerite C. Reising*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *Feb. 28, 1902*

8. AGE: Years Months Days If less than one day

*41**5**3*

hr.

min.

9. Birthplace *Baltimore Md.*

(Town, county, and state)

10. Usual Occupation *Foreman*11. Industry or business *Baltimore Transit Co.*12. Name *James E. T. Raynor*13. Birthplace *Baltimore Md.*14. Maiden Name *Matilda Kattenhorn*15. Birthplace *Baltimore Md.*16 (a) Informant *Marguerite C. Raynor*(b) Address *503 S. Savage St.*17 (a) *Burial* (b) Date thereof *8/3/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Oak Lawn*Location *Eastern Ave.*18 (a) Funeral director *Clarence F. Hoffmann*(b) Address *1639 N. Broadway.*19 (a) *AUG 3 - 1943**Huntington Williams, Jr.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *503 S. Savage St.*

(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *7/31* 19*43* at *4* M21. I certify that death occurred on the date above stated; that I attended deceased from *7/17* 19*43* to *7/31* 19*43*.and that I last saw him alive on *7/31* 19*43*.

Immediate cause of death

Coronary thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *J. Joseph J. J. J.*Address *441 P. Ellwood St.* Date signed *8/1/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06888

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1827 E. Chase St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louise Boothe

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1900

8. AGE: Years Months Days If less than one day

42 9 1 hr. min.

9. Birthplace Windsor Virginia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Jeremiah H. Klemm

13. Birthplace Va.

14. Maiden Name Gustavia Gwaltney

15. Birthplace Va.

16 (a) Informant John Boothe

(b) Address 1827 E. Chase St.

17 (a) Removal (b) Date thereof Aug. 3, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Windsor Virginia

18 (a) Funeral director Mrs. Robert A. Elliott & Co.

(b) Address 1129 N. Caroline St.

19 (a) Date of death

Aug 3 - 1943

(b) Date of registration

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1827 E. Chase St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1943 at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1943 to July 31, 1943, and that I last saw him alive on July 31, 1943.

Immediate cause of death

Cerebral apoplexy
acute myocardial infarction

Due to My peritonitis

Due to the fracture

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm. L. Berry M.D.

Address 1420 E. Chase Date signed Aug 3, 1943

Duration

3 days

1 day

3 mos.

6 mos.

1 year

2 years

3 years

4 years

5 years

6 years

7 years

8 years

9 years

10 years

11 years

12 years

13 years

14 years

15 years

16 years

17 years

18 years

19 years

20 years

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06889

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06889

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4405 N. Charles St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4405 N. Charles St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

TRESSIE J. SCHAUMAN

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband of ~~John~~ Albert Schauman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1864

8. AGE: Years Months Days If less than one day

79

5

29

hr.

min.

9. Birthplace Richmond Ave.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name William Johnson

13. Birthplace England

MOTHER

14. Maiden Name Rachael Collier

15. Birthplace England

16 (a) Informant Mrs. Hazel S. Claire

(b) Address 4405 N. Charles St.

17 (a) Burial (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa.

19 (a) AUG 9 1943 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1943, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1943, to Aug 2, 1943, and that I last saw him alive on Aug 1, 1943.

Immediate cause of death

Duration

Due to Cerebral Apoplexy 2nd attack.

Due to Hy/urtation in Head 1st attack of apoplexy

Other Conditions Syncope

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. J. Tickner and Sons M. D. Address 2200 Garrison Blvd Date signed 8-2-43

Please write in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06890

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3807 Birchview Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3807 Birchview Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

MAJOR ANDREWS JENKINS

3 (b) If veteran, name war

none

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Elizabeth Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1874

8. AGE: Years Months Days If less than one day

68

7

14

20

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

12. Name Robert Jenkins

13. Birthplace Va.

14. Maiden Name Emily Andrews

15. Birthplace Va.

16 (a) Informant Mrs. Elizabeth Jenkins

(b) Address 3807 Birchview Ave.

17 (a) Burial (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Baltimore Md.

18 (a) Funeral director M. J. TICKNER & SONS INC.

(b) Address North & Pa.

19 (a) AUG 3-1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 19 43, 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27, 1941, to Aug. 2, 1943, and that I last saw him alive on Aug. 2, 19 43.

Immediate cause of death

Carcinoma Bladder

Duration

Sept. 41

Due to Cardio-renal-vascular Disease

Sept. 41

Due to Metastasis (Abdominal) Apr. 43

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. N. Wilson

M. D.

Address 617 W. 40th St.

Date signed 8-2-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06831

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1133 Brewer St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Raymond Horatio Smith

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-09-8417

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1943, at 10 AM

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Helen

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

6-1-1892

8. AGE:

Years

Months

Days

If less than one day

51

1

30

hr.

min.

9. Birthplace

Delano Florida

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Davidson Chemical Co.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningitis

Due to Fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Jessie Hoines

(b) Address

1023 Penna. Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

July 4 1943

(c) Cemetery or crematory

Mt. Auburn Cemetery

Location

Mt. Vernon Md.

18 (a) Funeral director

Solophus Walstead

(b) Address

918 New Hill Ave.

19 (a)

(Date of registration)

(b) Registrar

Registrar

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 27 1943 9 PM

(b) Where did injury occur 1133 Brewer St

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury struck on the head with a chain

23. Signature Robert L. Graham M.D.

Date signed August 3 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 06892

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1410 (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Lee Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1943 to 8-1 1943 and that I last saw him alive on 8-1 1943

Immediate cause of death Respiratory failure

Due to Aplastic Anemia

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Arthur S. White

Address Providence Hosp. Date signed 8-3-43

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 1 Months 186 Days hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Robert Lee Johnson

13. Birthplace Md.

14. Maiden Name Ruth Johnson

15. Birthplace Md.

16 (a) Informant Ruth Johnson

(b) Address 1410 Argyle Ave.

17 (a) Burial (b) Date thereof 8-3-43 (month) (day) (year)

(c) Cemetery or crematory M.T. Calvary Cemetery

Location Cedar Hill Md.

18 (a) Funeral director Arthur S. White

(b) Address 918 David Hall Ave.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

(Date rec'd by registrar)

8-3-43

G 06893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06893

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2548 Frederick Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

widower

6 (b) Name of husband or wife Emma E. Yockel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Feb. 24, 1865

8. AGE: Years

18

Months

5

Days

87

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

12. Name

Charles B. Stoner

13. Birthplace

Maryland

14. Maiden Name

Susan Haines

15. Birthplace

Maryland

16 (a) Informant

Mr. Oliver F. Morris

(b) Address

2548 Frederick Ave

17 (a) Burial

(b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Old Frederick Rd.

18 (a) Funeral director

John J. Leguano & Son

(b) Address

1010 Belcham St.

19 (a)

(b)

AUG 3 - 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No

2548 Frederick Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 1, 1943, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21, 1943, to Aug 1, 1943, and that I last saw him alive on July 31, 1943.

Immediate cause of death

Pulmonary edema

Due to

Hypertension

Due to

Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Samuel J. Leguano

Address

221 Medical Center

Date signed

8/4/43

06894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06894
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Dukeland & Bayview*

(c) Hospital or institution

W. Balto Gen Hosp(d) Length of stay in hospital or inst. (yrs., mos., or days) *21*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Marvin Stewart Meyerhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

0 0 3 hr. min.

9. Birthplace

Baer, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Albert Meyerhoff*13. Birthplace *Germany*14. Maiden Name *Sylvia Brubaker*15. Birthplace *Balto. Md*

16 (a) Informant

(b) Address

*Map. Records*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *8-3-43*

(month) (day) (year)

(c) Cemetery or crematory

Rosedale

Location

18 (a) Funeral director

Joe Lewis Inc

Address

1429 E. Balto. St

(Date rec'd by registrar)

(b) *Huntington Williams, M.D.*

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town, write RURAL and give town)

(d) Street No.

518 W Franklin St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-2-43* 19 *Y.* at *2:30 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *July 30* 19 *43* to *Aug 2* 19 *43*.and that I last saw him alive on *19*

Immediate cause of death

Atelectasis

Due to

Premature birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature *Theron M. Cheek*Address *W.B.G.H.*

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06895
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Anchenbury Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Anchenbury Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Sylvia Brim
3 (b) If veteran, name war
3 (c) Social Security Account No. 320-09-5436

4. Sex Female
5. Color or race white
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Bernard R. Brim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909
8. AGE: Years 34 Months Days If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Faingle
13. Birthplace Russia

MOTHER
14. Maiden Name Clara
15. Birthplace Russia

16 (a) Informant Bernard R. Brim
(b) Address 3012 Anchenbury Terrace

17 (a) Burial (b) Date thereof Aug 4-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Joe Lewis Inc.,
Address 1343 E. Balto. St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Aug. 2nd 1943 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Aug 2, 1943, and that I last saw her alive on Aug. 2, 1943.

Immediate cause of death Exhaustion;
Metastatic Carcinoma
Due to Carcinoma of Breast
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation June 1942
Major findings of operation Carcinoma of left breast.
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert Goldstone
Address 743 Linden St. Date signed Aug 2, 1943

Duration 1 1/2 yrs
1 1/2 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

G 06896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06896

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2001 Brunt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2001 Brunt St

(If rural, give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Simpson

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Carrie Simpson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 12, 1896

8. AGE:

Years

Months

Days

If less than one day

47

5

15

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Thomas Simpson

13. Birthplace

Md

MOTHER

14. Maiden Name

Elizabeth Robinson

15. Birthplace

Md.

16 (a) Informant

Melched Fortune

(b) Address

5168 Baker St

17 (a)

Burial

(b) Date thereof

8/5/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Arbutus

Location

Md

18 (a) Funeral director

Wes. D. Kelso

(b) Address

1303 Pressman

19 (a)

1943

(b) Registrar

Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 1 1943 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1943 to Aug 1 1943, and that I last saw him alive on Aug 1 1943

Immediate cause of death

Coronary

Vascular Disease

Duration

Unknown

Due to

Broken Compensating July 12/43

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. William Trier

Address

1928 Pa. Ave

Date signed

8/3/43

AUG 3 1943

VS 1

G 06897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06897

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 507 E 23rd St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County -

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 E 23rd St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lawrence J. Ahern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color of race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/18/66

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual Occupation

Retired Conductor

11. Industry or business

Railroad

FATHER

12. Name

Lawrence Ahern

13. Birthplace

Ireland

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mrs J. Ahern

(b) Address

507 E 23rd St

17 (a)

Burial

(b) Date thereof

8-4-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Mary M. Theobald

(b) Address

501 E 23rd St

19 (a)

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd. 1943. at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9th. 1943. to Aug. 2nd. 1943. and that I last saw him alive on July 31st. 1943.

Immediate cause of death

Uremia

Duration

2 days

Due to

Chronic Parenchymatous Nephritis unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. W. Margary

Address

401 E. 25th. St.

Date signed

8/5/43.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4808 06898
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4817 Richard Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4817 Richard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Hazel Ruth Beckman

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 15, 1911

8. AGE:

Years

Months

Days

If less than one day

32

2

16

hr.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual Occupation

At home

11. Industry or business

12. Name

John W. Cindoff

13. Birthplace

Baltimore

14. Maiden Name

Eva B. Townsley

15. Birthplace

Balto County

16 (a) Informant

Fredrick Beckman

(b) Address

4817 Richard Ave

17 (a)

Burial

(b) Date thereof 8-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Prospect Hill

Location

Towson

18 (a) Funeral director

Leonard J. Ruck

(b) Address

4808 Harford Rd

19 (a)

(b)

(Date rec'd by registrar)

August 3, 1943

Registrar

VS 186

Med.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1, 1943 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12, 1943 to Aug 1, 1943, and that I last saw HER alive on July 31, 1943.

Immediate cause of death

Carcinoma of uterus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Carcinoma of uterus

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Ernest Sawyer

Address 4808 Harford Rd Date signed 8/3/43

G 06899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06899

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2400 Ashington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Carl H. Thistel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife Augusta E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 3, 1898

8. AGE:

Years

Months

Days

If less than one day

44

8

28

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Traffic Manager

11. Industry or business

FATHER

12. Name

Andrew Thistle

13. Birthplace

Norway

MOTHER

14. Maiden Name

Henrietta Rosenfeld

15. Birthplace

Norway

16 (a) Informant

Mrs Augusta Thistel

(b) Address

2400 Ashington Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8-4-43

(c) Cemetery or crematory

Woodlawn

Location

18 (a) Funeral director

J. R. Ruck

(b) Address

1813 25th St, Baltimore

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2400 Ashington Ave

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1943 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943, to Aug 1 1943, and that I last saw him alive on Aug 1 1943.

Immediate cause of death

Carcinoma Esophagus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma Esophagus

Of autopsy

Duration

5 Mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. W. Peake

Address 4508 Harford Rd Date signed 8-1-43

G 56300

BALTIMORE CITY HEALTH DEPARTMENT

G 05900

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

a) Baltimore City, Maryland

b) Street address

c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

a) State MD b) County

c) City or town

(If outside city or town limits, write RURAL and give town)

d) Street No.

(e) Citizen of foreign country

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

45

6

12

hr.

min.

9. Birthplace Calvert Co. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31 1943 at 3 A M

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06901

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06901

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

733 George St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

April 5 1895

8. AGE:

Years

Months

Days

At less than one day

48

3

16

hr

min

9. Birthplace

Baltimore md

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

James Bland

13. Birthplace

Balto md.

MOTHER

14. Maiden Name

unknown

15. Birthplace

unknown

16 (a) Informant

Jennie McAlister / Friend

(b) Address

733 George St.

17 (a)

Burial

(b) Date thereof

2-3-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

Baltimore md

18 (a) Funeral director

Charles H. Cooper

(b) Address

614 N. Calhoun St

19

3-1943

(Date rec'd by registrar)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

733 George St

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

Mary

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31

1943, at

30

PM

21. I certify that I took charge of the remains described above, held an

Inspection

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral

hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert E. Graham

M.D.

Date signed

July 31 1943

06902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06902

Registered No. 107

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 3, 1942

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

16 (b) Address

17 (a)

(Burial, cremation, or removal)

b Date thereof 8/4/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2 1943 at 10:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1943, to 8-2 1943, and that I last saw her alive on 8-2 1943.

Immediate cause of death Asphyxia & respiratory failure

Due to Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address Providence Hospital Date signed 8-3-43

Duration

16 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

AUG 3 - 1943

Huntington Williams, M.D.

06903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06903
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days)

3. a. FULL NAME

3. (b) If veteran, name war

4. Sex

6. (b) Name of husband or wife

7. Birth date of deceased mo., day, yr

8. AGE: Years Months Days

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. (a) Informant

17. (a) Burial, cremation, or removal

18. (a) Funeral director

19. (a) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

a. State

b. County

c. City or town

d. Street No.

(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the day above stated; that I attended deceased from Jan 11 1943 to Aug 7 1943 and that I last saw her alive on 7/30/43

Immediate cause of death

Due to

Due to

Other Conditions

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Duration

Several years

PHYSICIAN

Indicate the area to which health should be referred statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06904
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days

3. (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 3 1943

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1943, to July 23 1943, and that I last saw her alive on July 23, 1943.

Immediate cause of death

Due to Congenital Monstrosity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

Duration

3 hrs alive

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06905

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Glenison St.
(c) Hospital or institution: Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand J. Haber

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M. 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Ada Hudson Haber 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1881

8. AGE: Years 62 Months 13 Days 13 If less than one day hr min.

9. Birthplace Germany (town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B. & O. T. R.

12. Name Christopher Haber

13. Birthplace Germany

14. Maiden Name Joglehardt

15. Birthplace Germany

16 (a) Informant Henry L. Hatchinson

(b) Address 1833 Frederick Ave

17 (a) Burial (b) Date thereof Aug 4/43 (month) (day) (year)

(c) Cemetery or crematorium Landon Pk.

Location 3801 Frederick Ave

18 (a) Funeral director Harry H. Untch

(b) Address 4101 Edmondson Ave

19 (a) Date of registration AUG 3-1943 (b) Registrar

VS 114

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1943 at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943 to Aug 1 1943, and that I last saw him alive on July 31 1943.

Immediate cause of death
Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas B. Schreiber

Address 54 S. Fulton Ave Date signed 8-2-43 M. D.

Duration
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06906
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1922 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 40 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1943, to Aug 1 1943, and that I last saw him alive on Aug 1 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

V8 188

AUG 3-1943

Huntington Registrar

1934 Wilkens Ave

8/3/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06907
48911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lawrence Carnan

3 (b) If veteran, name war

3 (c) Social Security Account
No. ?

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Grace {D}

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr. 20, 1892

8. AGE:

Years

Months

Days

If less than one day

51

3

11

hr.

min.

9. Birthplace

Tenn.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

Robert Carnan

13. Birthplace

Md.

14. Maiden Name

Ida Wyatt

15. Birthplace

Md.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8-4-43

(c) Cemetery or crematory

London Park

Location

Baltimore Md.

18 (a) Funeral director

Harry H. Kintner

(b) Address

4101 Edmondson Ave.

19 (a)

(Date rec'd by registrar)

(b)

Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-1

1943, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1943, to 8-1 1943, and that I last saw him alive on 8-1 1943.

Immediate cause of death

HEVD - left ventricle -
respirator accident

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Not done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

THOMAS

M.D.

Address

B. C. H.

Date signed 8-3-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 06908
CERTIFICATE OF DEATH		Registered No.
1. PLACE OF DEATH: Baltimore City, Maryland		2. USUAL RESIDENCE OF DECEASED: a. State <i>Md</i> (b) County c. City or town <i>Baltimore</i> (If outside city or town limits, write RURAL and give town) d. Street No. <i>2400 East Hoffman St.</i> (If rural give location) e. Citizen of foreign country? (Yes or No) If yes, name country
3 (a) FULL NAME <i>Mr. William Mc Guire</i>		MEDICAL CERTIFICATION 20. DATE OF DEATH <i>Aug 1, 1943</i> at <i>10:03 P.M.</i> 21. I certify that death occurred on the date above stated; that I attended deceased from <i>June 12, 1943</i> to <i>Aug 1, 1943</i> , and that I last saw him alive on <i>Aug 1, 1943</i> . Immediate cause of death <i>Chronic Cardiac Failure</i> Due to <i>Arteriosclerotic Cardiovascular Disease</i> Due to Other Conditions <i>Arteriosclerotic</i> <i>Hypertension - 1st foot</i> (Include pregnancy within 3 months of death) Date of operation <i>7-31-43</i> Major findings of operation: <i>Amputation, mid-calf, 7th leg.</i> of autopsy: 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? (e) Means of injury 23. Signature <i>J.M. Puller Jr.</i> Address <i>Church Home & Hospital</i> Date signed <i>8-1-43</i>
3 (b) If veteran, name war <i>No</i> 3 (c) Social Security Account No. <i>212-12-9166</i>		
4. Sex <i>Male</i> 5. Color or race <i>White</i> 6 (a) Single, married, widowed, or divorced. <i>Married</i>		
6 (b) Name of husband or wife <i>Dora Mc Guire</i> 6 (c) If alive, give age years		
7. Birth date of deceased mo., day, yr. <i>Aug 5 1873</i>		Duration <i>10 days</i> <i>70 days</i> PHYSICIAN Underline the cause to which death should be charged statistically.
8. AGE: Years <i>69</i> Months <i>11</i> Days <i>26</i> If less than one day hr. min.		
9. Birthplace <i>New York, N.Y.</i> (Town, county, and state)		
10. Usual Occupation <i>Builder</i>		
11. Industry or business		
FATHER	12. Name <i>William Mc Guire</i>	
	13. Birthplace <i>New York N.Y.</i>	
	14. Maiden Name <i>Budget Kehoe</i>	
MOTHER	15. Birthplace <i>Ireland</i>	
	16 (a) Informant <i>Mrs Dora Mc Guire</i> (b) Address <i>2400 E. Hoffman St.</i>	
17 (a) <i>Burial</i> (b) Date thereof <i>Aug 4, 1943</i> (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory <i>New Cathedral Cemetery</i> Location <i>4300 Old Frederick Rd.</i>		
18 (a) Funeral director <i>James W. Conklin</i> (b) Address <i>924 E. Eager St.</i>		
19 (a) (b) (Date of registration) (Signature) <i>AUG 3 - 1943</i> Registrar		

G 06909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06909
Registered No.

82920

YA

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4940 Eastern Ave.
- (c) Hospital or institution:
BALTIMORE CITY HOSPITALS
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
- (e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

3 (a) FULL NAME

James Humphries

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-5-1905

8. AGE:

Years

Months

Days

If less than one day

38226

hr.

min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation Laborer11. Industry or business American Brewery12. Name Tom Humphries13. Birthplace N. C.14. Maiden Name Mollie Hew15. Birthplace N. C.16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(RECORDS)17 (a) removal

(b) Date thereof

8 3 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Durham N. C.

18 (a) Funeral director

Philip Herring Sons

(b) Address

2024 Orleans St.

G 3-1943

Registrar Huntington Williams, M.D.

VS 150

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1212 W. Fayette St.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1943 at 6-AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1943 to 8-1 1943, and that I last saw him alive on 8-1 1943.

Immediate cause of death

Pneumonia, Friedlander

Duration

3 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
- (e) Means of injury

23. Signature

Paul Mattman

Address

B. C. H.

Date signed

8-1-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

06910
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *355 N Calvert St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years Months Days
If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name *George Fitzpatrick*

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Funeral* (b) Date thereof *8/4/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/2* 19*43* at *3:15 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *7/31* 19*43* to *8/2* 19*43*, and that I last saw him alive on *8/2* 19*43*.

Immediate cause of death

Cardiac Failure

Due to *Traumatic Shock*

Due to *Mesenteric thrombosis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *8/1/43*

Major findings of operation:

Extensive Mesenteric thrombosis of autopsy.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address *Murcy Hosp.*

Date signed *8/2/43*

AUG 3 1943

G 06911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06911

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2 North High St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

James Mc Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. March 15, 1900)

8. AGE: Years 43 Months Days If less than one day hr. min.

9. Birthplace Quincy, Mass

(Town, county, and state)

10. Usual Occupation

unknown

11. Industry or business

12. Name John D. Mc Neal

13. Birthplace Boston, Mass

14. Maiden Name Elizabeth S. Kavanaugh

15. Birthplace Boston, Mass

16 (a) Informant Mrs. E. F. White

(b) Address 801 Spetham Artery - Mass.

17 (a) Burial (b) Date there Aug 6, 1943

(Burial, cremation, or removal) (month, day, year)

(c) Cemetery or crematorium St. Mary's Cem.

Location Randolph, Mass

18 (a) Funeral director Frederick J. Galt

(b) Address 1706 N. Lombard St.

19 (a) Registrar Howard W. Williams

Date signed 8/3/43

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1943, at 10:00 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic

pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature Robert Lee Euston M.D.

Medical Examiner.

Date signed 8/3/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UG 3-1943

HEALTH DEPARTMENT—CITY OF BALTIMORE

06912

6912

CERTIFICATE OF DEATH

51B

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Dennis St. 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U.S. Veteran
specify WAR

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

Richard Hymiller

(a) Residence: No.

145 Liberty W Westminster Md Carroll Co.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. Color or Race W	5. Single, Married, Widowed, or Divorced (write the word) Single
-------------	-----------------------	---

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Oct 3, 1871.

7. AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
71		9	" -	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	worked at Rising Quarry
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	1936
	11. Total time (years) spent in this occupation	

12. BIRTHPLACE (city or town)
(State or country) Union Bridge
Carroll Co Md

13. NAME John N. Hymiller

14. BIRTHPLACE (city or town)
(State or country) Mayberry
Carroll Co Md

15. MAIDEN NAME Agnes R. Yingling

16. BIRTHPLACE (city or town)
(State or country) Westport
Md17. INFORMANT Frank M. Hymiller
(Address) 2700 Eleanor Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Union Bridge Md Date Aug. 6, 1943

19. UNDERTAKER Bankard & Son
(Address) Westminster Md

20. FILED

AUG 9 - 1943

Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 3, 1943

22. I HEREBY CERTIFY. That I attended deceased from

July 9, 1943, to Aug 3, 1943

I last saw him alive on Aug 3, 1943 Death is said

to have occurred on the date stated above, at 2:30 P.M.

The principal cause of death and related causes of importance were as follows:

Carcinoma Prostate

Other contributory causes of importance:

Metastasis to
Liver

Was an operation performed? no Date of

For what disease or injury?

What test confirmed diagnosis? apto copy Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify

(Signed) Sydney Wallenstein, M.D.

(Address) 2042 Eutan Place

Baltimore Md.

G 06913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 8 - 1943

VS 8

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1943 to 8/2 1943 and that I last saw him alive on 8/2 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06914
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

907 W. Madison St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary Jansky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Thomas Jansky

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

April 15, 1867

8. AGE:

Years

Months

Days

If less than one day

76

3

14

hr.

min.

9. Birthplace

Bohemia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Joseph Petr

13. Birthplace

Bohemia

14. Maiden Name

Marie Bharvat

15. Birthplace

Bohemia

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

8-4-43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore Ind.

18 (a) Funeral director

Trinity Church

(b) Address

900 N. Chester St

AUG 4 - 1943

Wm. H. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

907 W. Madison St

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 1

1943, 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4, 1943, to Aug 1, 1943, and that I last saw her alive on July 31, 1943.

Immediate cause of death

Cerebral Hemorrhage (apoplexy)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph Pokorny

Address

2200 W. Madison St

Date signed 8/2/43

Duration

2 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

06915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06915
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1921 Clifton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1921 Clifton Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LEO

OSTRAW

3 (b) If veteran, name war

3 (c) Social Security Account

No. 219-12-8001

4. Sex

W

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Emme

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1886

8. AGE:

Years

Months

Days

If less than one day

57

hr.

min.

9. Birthplace

New York City

(Town, county, and state)

10. Usual Occupation

Soldier

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Ostraw

13. Birthplace

N. Y.

14. Maiden Name

Rachel

15. Birthplace

N. Y.

16 (a) Informant

Wife

(b) Address

17 (a)

Burial

(b) Date thereof

8-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Hempfield
P.H. Rd + Barclay Lane.

Location

18 (a) Funeral director

Park Lawn Inc.

(b) Address

1439 E. Balt St.

19 (a)

AUG 4-1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1943, at 12 PM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallerstein M.D.

Date signed 8-2-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93DG 06916
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2320 Eutaw Place
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 13
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
 (c) City or town Balt.
 (If outside city or town limits, write R.R. No. and give town)
 (d) Street No. 2320 Eutaw Place
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Louis Hollander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Miriam
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 63 Months Days If less than one day
 hr. min.

9. Birthplace Austria
(Town, county, and state)10. Usual Occupation Lawyer

11. Industry or business

12. Name Charles Asher Hollander13. Birthplace Austria14. Maiden Name Edith15. Birthplace Austria16 (a) Informant Wife

(b) Address

17 (a) Burial (b) Date thereof 8-4-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Belair ParkLocation Baltimore City18 (a) Funeral director Jack Deane(b) Address 1432 E. Pratt St.Pharmington WilliamsAUG 4 - 1943

VS 140

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-43 19 43 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1940 to Aug 2 1943, and that I last saw him alive on Aug 1 1943.

Immediate cause of death

Coronary ThrombosisDue to Chronic Myocarditiswith arterio sclerosis

Due to

Other Conditions Chronic AtrophyArthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph ZierlerAddress 2318 Eutaw Place8/2/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06917

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —(c) City or town Baltimore(d) Street No. 1804 Byrd St. (If outside city or town limits, write RURAL and give town)(e) Citizen of foreign country? — (If rural give location)(f) If yes, name country — (Yes or No)

3 (a) FULL NAME

Mary Amelia Kavelage3 (b) If veteran, name war —3 (c) Social Security Account No. —

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John H. Kavelage6 (c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) April 14 - 18878. AGE: Years 56 Months 3 Days 17 If less than one day hr. min.9. Birthplace Balto Md. (Town, county, and state)10. Usual Occupation Housewife11. Industry or business at home12. Name Carl Gang.13. Birthplace Germany.14. Maiden Name Minkum15. Birthplace Germany16 (a) Informant Mr. John H. Kavelage(b) Address 1804 Byrd St.17 (a) Burial (b) Date thereof Aug. 5 - 43 (month) (day) (year)(c) Cemetery or crematory Valley Cross.Location Brooklyn Md.18 (a) Funeral director Jos. E. Beyer Jr.(b) Address 1612 Hollins St.AUG 4 - 1943 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1943 at 9:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1943 to Aug. 1 1943, and that I last saw her alive on Aug. 1 1943.Immediate cause of death Pulmonary embolismDue to Thrombosis caused by diabetic gangreneDue to —Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —Major findings of operations: —of autopsy: —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?(e) Means of injury —23. Signature Paul H. Subate M. D.Address 1213 Light St. Date signed Aug 4 1943

06918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06918
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 83rd + Calvert Sts.

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1010 W. 38th St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ELIZABETHThompson

3 (b) If veteran, name was

3 (c) Social Security Account

No.

None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

John A. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 6 - 1871

8. AGE:

Years

Months

Days

If less than one day

7222526

hr.

min.

9. Birthplace

Montgomery Co. Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

Thomas Hater

13. Birthplace

Md

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mr. John A. Thompson

(b) Address

1010 W 38th St

17 (a)

Burial

(b) Date thereof

Aug 5 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Meadowridge Cem

Location

Dorsey Md

18 (a) Funeral director

Geo. E. Beyer Jr

(b) Address

1517 Hollins St

AUG 4 - 1943

(b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8 - 2 -1943, at12:05 AM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

Fractured ribs + clavicleMultiple ecchymoses + lacerations

(Include pregnancy within 5 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

8-1-43

at

9 P. 1/2

(b) Where did injury occur?

36th St. + Roland Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? PublicWhile at work? No

(d) Means of injury

Struck by street car

23. Signature

Howard J. Walden

M.D.

Date signed 8-2-43

Medical Examiner.

A correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06919

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 45 gals

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2714 Harlem Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward E. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-03-0709

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Katie A. Bowen

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1881

8. AGE: Years Months Days If less than one day

61

11

6

hr.

min.

9. Birthplace Calvert County - Md.

(Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Shoe Manufacturing Co.

12. Name Eliph Bowen

13. Birthplace Calvert Co., Md.

14. Maiden Name Mallie King

15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Katie A. Bowen

(b) Address 2714 Harlem Ave

17 (a) Burial (b) Date thereof August 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Md.

18 (a) Funeral director George W. Little,

(b) Address 2700 Edmondson Ave.

(c) Signature Hunter for Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 1943, at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of pelvis

Due to struck by truck

Other Conditions Hemorrhage, abdominal

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-2-43 at 6: P.

(b) Where did injury occur? Edmondson Ave & Oak -

(c) Did injury occur at home, on farm, industrial place, in public

place? Public While at work? No

(d) Means of injury Was getting of package when he

23. Signature H.M. Williams, M.D.

Date signed 8-3-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06920

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2309 Ocala Ave.

(c) Hospital or institution:

Finley Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2309 Ocala Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Carrie Elizabeth Gott

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife William H. Gott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1865

8. AGE: Years Months Days If less than one day

78

6

28

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name David H. Crowl

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Caroline Greble

15. Birthplace Baltimore, Md.

16 (a) Informant Pearre E. Crowl

(b) Address Ambassador Apts.

17 (a) Burial (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director H. J. TICKNER & SONS INC.

(b) Address North & Pa Aves.

19 (a) AUG 4 - 1943

Registrar

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1943. 8:20P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1942 to Aug 2 1943, and that I last saw him alive on Oct 25 1943.

Immediate cause of death

Myocarditis

Due to Atherosclerosis

Hypertension

Due to

Other Conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. J. TICKNER & SONS INC. M. D.

Address 2220 Garrison Date signed Aug 3/43

Duration of illness 4 mos.

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

G 06921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 06921
467
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 E. 32nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mrs. ELLEN W. HARBERTS

3 (b) If veteran, name was none
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Meinhard A. Harberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1874
8. AGE: Years 69 Months 1 Days 9 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Rauch
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. M. A. Harberts
(b) Address 1905 E. 32nd St.

17 (a) Burial (b) Date thereof 8/4/43
(Burial, cremation, or removal) (month/ (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore, Md.

18 (a) Funeral director H. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves.

19 (a) (b) Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 43 3:17AM
21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1942 to Aug 1 1943 and that I last saw him alive on Aug 1 1943.

Immediate cause of death
Carcinoma of rectum

Due to
Due to

Other Conditions Metastasis - general

(Include pregnancy within 3 months of death)
Date of operation October 6 - 1942
Major findings of operation: Carcinoma of rectum
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benjamin H. Adams M. D.
Address 2306 E. 2nd St. Date signed 8-2-43

AUG 4 - 1943

G 06922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06922
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 84 days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3003 Clifton Avenue

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

JAMES W. GRESHAM

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 228-16-4447

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Lena M. Richard

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) May 1, 1873

8. AGE: Years

70 yrs.

Months

3

Days

1

If less than one day

hr.

min.

9. Birthplace White Stone, Va.

(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business 2nd Officer, Mer. Marine

12. Name James Robert Gresham

13. Birthplace White Stone, Va.

14. Maiden Name Louemma McClanahan

15. Birthplace Northumberland Co., Va.

16 (a) Informant Records, U.S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa. Aves.

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Aug. 2, 1943. at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10, 1943. to Aug. 2, 1943. and that I last saw him alive on Aug. 2, 1943.

Immediate cause of death

Degenerative lesion spinal cord

Duration

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. S. Brown

Address Baltimore, Md.

Date signed 8/2/43

MS-45937

Aug 4 - 1943

Huntington Williams M.D.

06923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06923
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2466 Druid Hill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) - 13

(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)(d) Street No. 2466 Druid Hill Ave
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Estella Turner

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

F

5. Color or race

col.

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 15, 1903

8. AGE:

Years

Months

Days

If less than one day

40

5

18

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

cook

11. Industry or business

FATHER

12. Name

Chas. Turner

13. Birthplace

Md

MOTHER

14. Maiden Name

Mary Reynolds

15. Birthplace

Md

16 (a) Informant

Nellie Morgan

(b) Address

2466 Druid Hill Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 8/6/43
(month) (day) (year)

(c) Cemetery or crematory

Elkridge

Location

Md

18 (a) Funeral director

Geo. H. Nelson

(b) Address

1303 Presstman

19 (a)

(Date rec'd by registrar)

August 4, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 3, 1943, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21, 1943, to Aug 3, 1943, and that I last saw her alive on Aug 2, 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

10 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

L. O. Blum

Address 2329 Euphrates

Date signed

Aug 17, 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06924

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 1426 Parrish Street

(b) Street address Baltimore, Maryland

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HOSA HICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 6, 1943

8. AGE: Years

Months

Days

If less than one day

3 2

26

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER

12. Name

Harry Hicks

13. Birthplace

Md

MOTHER

14. Maiden Name

Bertha Wilson

15. Birthplace

Md

16 (a) Informant

Harry Hicks

(b) Address

1426 N. Parrish St

17 (a)

Burial

(b) Date thereof

8/5/43

(Burial, cremation, or removal)

(month, day) (year)

(c) Cemetery or crematory

St Peter

Location

Md

18 (a) Funeral director

W. S. Nelson

(b) Address

1303 Pressman St

19 (a)

Date rec'd by registrar

1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1426 Parrish Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2,

1943, at

9:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Diarrhea Infantile, Probably nutritional.

Cause undetermined.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. S. Nelson M.D.

Date signed 8-3-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SM
G 06925
82034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1086 06925
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4240 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1543 Leslie St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Charles White
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lillie White
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) March 9, 1904
8. AGE: Years Months Days If less than one day
39 4 29 23 hr. min.
9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Musician
11. Industry or business
12. Name George (d)
13. Birthplace N.C.
14. Maiden Name Minnie Gevald
15. Birthplace N.C.
16 (a) Informant Baltimore City Hospitals
(b) Address (Records)
17 (a) Burial (b) Date thereof Aug 5-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Not Calvary
Location a a. co. not
18 (a) Funeral director James Adams
(b) Address 142 W. 11th St.
19 (a) (b)
AUG 4 - 1943 Huntington Williams

MEDICAL CERTIFICATION
20. DATE OF DEATH 8/2 1943 11:15 AM
21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 8/2 1943.
and that I last saw him alive on 7/2 1943.
Immediate cause of death Pul. embolus
Cor. occlusion (P) hypertensive
Due to Lobar pneumonia
Heart disease
Due to
Other Conditions At. lower
pneumonia 2 prob. causes
(Include pregnancy within 9 months of death)
Date of operation
Major findings of operation
Mal. infarct to spleen & kidney
caus. hypertensive & mural thrombosis
of aorta. Lung abscess ruptured into pleura / M
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Seigman
Address A C H Date signed 7/3

Duration
2 hr.
4 md.
PHYSICIAN
Underline the
cause to which
death should be
charged statis-
tically.
HARRIS

AD-48289

06926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06926

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **4840 Eastern Ave.**
 (c) Hospital or institution: **Baltimore City Hospitals**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **3 yr, 10 mos. 19 days**

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **708 N. Eden St.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mamie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 29-1912

8. AGE

31

Years

Months

1

Days

2

If less than one day

hr.

min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

David Hill

13. Birthplace

Md.

14. Maiden Name

Annie Scofield

15. Birthplace

Md.

16 (a) Informant

Baltimore City Hospitals

(b) Address

Records

17 (a)

Burial

(b) Date thereof

8/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cem

Location

Brooklyn L. & Co. Rd

18 (a) Funeral director

Mrs. Ida Bailey

(b) Address

1421 Jefferson St

19 (a)

1943

(b)

Registrar

AUG 4 1943**Thurston Williams, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/1 1943 at 11:40 A

21. I certify that death occurred on the date above stated; that I attended deceased from **7/1 1943** to **8/1 1943** and that I last saw her alive on **7/1 1943**

Immediate cause of death

Pulmonary tuberculosis

Duration

4 1/2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Ad. change

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Jergman

Address

B C H

Date signed

8/2

G 06927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 06927
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1781 Montpelier Street
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1781 Montpelier Street
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME

James H. Lance

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Laura V. Ellis

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 8th, 1857

8. AGE: Years 85 Months 7 Days 25 If less than one day
min.

9. Birthplace Baltimore Md.

(Town, county, and state) Porter

10. Usual Occupation Retired Foreman Shop

11. Industry or business Penna RR. Shops.

12. Name Christopher Lance

13. Birthplace Germany

14. Maiden Name Martha Stainhagen

15. Birthplace Maryland

16 (a) Informant Miss Laura F. Lance (Daughter)

(b) Address 1781 Montpelier Street

17 (a) Burial (b) Date thereof 8/5/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood
Location Taylor Ave. Baltimore, Md.18 (a) Funeral director George J. Ruth, Inc.
1735 Harford Avenue

19 (a) (Date rec'd by registrar) AUG 4 1943 (b) Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3rd. 19 43 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/31 1943 to 8/3 1943.
and that I last saw him alive on 8/2 19 43

Immediate cause of death

Arterio-sclerotic
An. myocarditis

Due to

Smile

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. H. Lance
Address 1901 Euter Date signed 8/4/43

Duration

1 yr

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06928

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

61

6

22

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1943 to 8/4/1943.

and that I last saw him alive on 8/4/1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: splenomegaly, infection

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important

06929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06929
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 508 S. Bethel St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2/3

(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

3 (a) FULL NAME

3 (b) If veteran, name and grade

3 (c) Social Security Account No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank Trasher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1873

8. AGE: Years 70 Months 6 Days -1 hr. min.

9. Birthplace

Poland
(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name Father

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mary Trasher

(b) Address 521 S. Bond Street

17 (a) Burial (b) Date thereof 8/5/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Rosary Cemetery
Location Baltimore County

18 (a) Funeral director John W. Welch

(b) Address 401 S. Chesapeake Street

19 (a) (b) Huntingdon Williams, M.D.
(Date registered) (Signature) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 508 S. Bethel St

(If rural give location)

(e) Citizen of foreign country? Yes (No or No)

If yes, name country Poland

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1943. at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1943. to Aug 2 1943. and that I last saw her alive on Aug 2 1943.

Immediate cause of death

Abdominal distention caused

by Gastric Carcinoma

Due to Gastric Carcinoma

Due to

Other Conditions Pericarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Mary Trasher

Address 200 E. Pratt Date signed 8/5/43

Duration

acute

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 4 1943

G 06930

CARROLL
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06930

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

18

Months

10

Days

3

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(If outside city or town limits, write RURAL and give town)

(If rural give location)

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-3

1943, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1943, to 8-3 1943, and that I last saw her alive on 8-3 1943.

Immediate cause of death

Obstruction

Due to

abdominal adhesions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8-3-43

Major findings of operation:

gills and junction

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Bernard Harris

Address

President Hosp.

Date signed

8-7-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06931

BALTIMORE CITY HEALTH DEPARTMENT

G 06931

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-107317

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2

1943, at 2:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1943, to 8-2 1943,

and that I last saw him alive on 8-2 1943.

Immediate cause of death Peritonitis

Duration

Due to

Ruptured Tubo-ovarian abscess

Due to

Other Conditions

none

(Include pregnancy within 3 months of death)

Date of operation

8-1-43

Major findings of operation: Large amount

of chocolate pus found odor

of autopsy:

none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

R. L. Jackson

Address

Provident Hospital

Date signed 8-4-43

B- 06932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06932
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) City or town Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1121 N. Gay St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Vincent Spotswood

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
M5. Color or race
C6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.)

6/23/1922

8. AGE: Years 21 Months 1 Days 9 If less than one day
hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Gay Spotswood

13. Birthplace Pa.

14. Maiden Name Mabel Jones

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof Aug 8/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Calvary Am
Location G.A. County Md

18 (a) Funeral director Mrs R. P. Elliott

(b) Address 1129 N. Caroline St.

19 (a) (b)
(Date rec'd by registrar)

AUG 4 - 1943

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1943, 3:55 A

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 8/2 1943.
and that I last saw him alive on 7/2 1943.

Immediate cause of death

Pulmonary Tuberculosis

Dyspnea

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. J. Seigman

Address A C H Date signed 8/13

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06933

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
South Baltimore General Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. - no home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

RALPH COOKE

3 (b) If veteran, name war

3 (c) Social Security Account
No. 214-14-57664. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or divorced
Single

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

1883

8. AGE:

Years

Months

Days

If less than one day

60

hr.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

Machinist

11. Industry or business

FATHER

12. Name John P Cook

13. Birthplace

Ind

MOTHER

14. Maiden Name Annie V Craig

15. Birthplace

Ind

16 (a) Informant Mrs Rhoda Cook

(b) Address Rock Pt. G. A. Co. Ind

17 (a) Burial

(b) Date thereof

8/6/43
(month) (day) (year)

(c) Cemetery or crematory

Edgar Hill

Location

Brooklyn Ind

18 (a) Funeral director

William M. Marek

(b) Address

715 Light St

19

AUG 1 - 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1943 at 4:10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cirrhosis of the liver, atrophic;
Chronic alcoholism.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. A. Wallenmeyer M.D.

Certified Medical Examiner.

Signed 8-3-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06934
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address **6117 Birchwood Ave.**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **unknown**(e) Length of stay in Baltimore (yrs., mos., or days) **unknown**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Balto.**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **6117 Birchwood Ave.**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

 CARL WEBSTER RICE

3 (b) If veteran, name war

 World War I

3 (c) Social Security Account No.

4. Sex

 male

5. Color or race

 white

6 (a) Single, married, widowed, or divorced.

 married 6 (b) Name of husband or wife **Emma L. Rice**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 18, 1895**

8. AGE:

Years

Months

Days

If less than one day

 47 **10** **15**

hr.

min.

9. Birthplace **Cumberland, Md.**

(Town, county, and state)

10. Usual Occupation **Automotive Inspector** 11. Industry or business **U.S. Govt.** 12. Name **Andrew M. Rice** 13. Birthplace **Cumberland, Md.** 14. Maiden Name **Sarah Ellen Brandt** 15. Birthplace **Bedford Co., Pa.** 16 (a) Informant **Mrs. C. W. Rice,** (b) Address **6117 Birchwood Ave.** 17 (a) **burial** (b) Date thereof **Aug. 6, 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **Balto. Natl.** Location **Balto., Md.** 18 (a) Funeral director **L. S. L. Funeral Home** (b) Address **477 N. Hollins Rd.**

19 (a) (b)

(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 3, 1943, 2:50 PM** 21. I certify that death occurred on the date above stated, that I attended deceased from **Aug 5, 1943** and that I last saw him alive on **Aug 3, 1943**

Immediate cause of death

Due to **Chronic Tuberculosis of lungs** Due to **Asthma** Other Conditions **Chronic Bronchitis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address **477 N. Hollins Rd.** Date signed **Aug 6, 1943**

Duration

YRS

MOS

WKS

DAYS

HRS

MIN

PHYSICIAN

Underline the cause to which death should be charged statistically.

43868935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06935

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1707 BARNES

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Edges

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

MAMIE6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

6-17-03

8. AGE:

Years

Months

Days

If less than one day

40117

hr.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Edges

13. Birthplace

S.C.

14. Maiden Name

Sallie Robinson

15. Birthplace

S.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Aug 7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Calvary Cemetery

Location

G. G. County Md

18 (a) Funeral director

Robert G. Elliott & Son

(b) Address

1129 N. Caroline St.Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 41943 at 4:08 A21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1943 to Aug 4 1943 and that I last saw him alive on Aug 4 1943.

Immediate cause of death

Respiratory Failure

Due to

Cardiac Failure

Due to

Arteriosclerotic Heart Disease& Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Chas. C. Cline

Address

Johns Hopkins Hospital

Date signed

8-4-43

G 06936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06936
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1029 N. Caroline Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1029 N. Caroline St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Levi

Levell

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Widowed

6 (b) Name of husband or wife

Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 2, 1884

8. AGE:

Years

Months

Days

If less than one day

58

9

6

hr.

min.

9. Birthplace

Richmond Va

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

Isaac Levell

13. Birthplace

Va.

14. Maiden Name

Matilda?

15. Birthplace

Va.

16 (a) Informant

Bertha Durham

(b) Address

1612 Miller St

17 (a)

Burial

(b) Date thereof

July 5, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Calvary Ceme.

Location

A.A. County Md

18 (a) Funeral director

Mrs R. U. Elliott & Dpt

(b) Address

1029 N. Caroline St

AUG 4 - 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1943 at 10:30 AM

21. I certify that I took charge of the remains described above, held an
Inspection & Inquiry
thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis
Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed

Aug 4 1943

G 06937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06937
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1227 N. Patterson Pl. Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Joe C. Armstrong

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 3rd 1859

8. AGE: Years Months Days

84

6

29

If less than one day

hr.

min.

9. Birthplace

N. Y.

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

FATHER
MOTHER

12. Name

Peter Wittmer

13. Birthplace

Germany

14. Maiden Name

Louisa Schild

15. Birthplace

Germany

16 (a) Informant

Mrs. Emma Wilderbrandt

(b) Address

1227 N. Patterson Pl. Ave.

17 (a)

Burial

(b) Date thereof

8/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore, Md.

18 (a) Funeral director

C. J. Fanning & Son

(b) Address

1938 E. Lafayette Ave.

19 (a)

Huntington Williams, M.D.

(b) Registered by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1227 N. Patterson Pl. Ave.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 2nd 1943 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1943, to Aug. 2 1943, and that I last saw him alive on Aug. 1, 1943.

Immediate cause of death

Carcinoma of liver

Duration

5 mos. +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

C. J. Fanning

Address

432 S. Patterson Pl. Ave.

Date signed 8/2/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 4-1943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

6938

6938

PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St., Ward 3)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city or town where death occurred: Life mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

GEORGE W. GREWE

(a) Residence: No. 2226 Cedley St.

(Usual place of abode)

St. Ward.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. Color or Race White	5. Single, Married, Widowed, or Divorced (write the word) Single
----------------	---------------------------	---

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) January 21, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	6	12	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School Boy

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

13. NAME Henry H. Grewe

14. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

15. MAIDEN NAME Eva E. Allick

16. BIRTHPLACE (city or town) West Virginia
(State or country)17. INFORMANT Mrs. Henry H. Grewe
(Address) 2226 Cedley St.

18. BURIAL, CREMATION, OR REMOVAL

Place Glen Haven Cem. Date August 6, 1943

19. UNDERTAKER
(Address) 1003 W. Baltimore St.

AUG 4 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 3, 1943

22. I HEREBY CERTIFY, That I attended deceased from 7-29 1943 to 8-3 1943

I last saw him alive on 8-3 1943. Death is said to have occurred on the date stated above, at 10:42 a.m.

The principal cause of death and related causes of importance were as follows:

Generalized peritonitis

Other contributory causes of importance:

Ruptured appendix

Name of operation Appendectomy Date of 7-29-43

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

H. P. Friedman M.D.

1317 C St. SE

G 06939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06939
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

3 (a) FULL NAME

Mrs. Anna Davis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Joseph P. Davis

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

Feb. 4, 1891

8. AGE:

Years

Months

Days

If less than one day

58

6

2

hr.

min.

9. Birthplace Baltimore County, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

John Hoyle

13. Birthplace

Md.

MOTHER

14. Maiden Name

Mary Martin

15. Birthplace

Md.

16 (a) Informant Joseph P. Davis (Husband)

(b) Address 8062 Roslyn Ave., Rosedale, Md.

17 (a) Burial, cremation, or removal

(b) Date thereof Aug. 6, 1943

(c) Cemetery or crematory Mt. Olivet Cem.

Location Baltimore, Md.

18 (a) Funeral director A. B. Crawford Evans

(b) Address 1400 N. Caroline St.

(c) Telephone No. 1-1844

19 (a) Date rec'd by registrar

AUG 4 - 1943

Washington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore

(c) City or town

Rosedale

(If outside city or town limits, write RURAL and give town)

(d) Street No.

8062 Roslyn Ave.

(e) Citizen of foreign country? (If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1943, 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1943, to Aug. 3, 1943, and that I last saw her alive on Aug. 3, 1943.

Immediate cause of death

Congestive Heart Failure

Due to Arteriosclerotic C-U disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Lusting

Address H. Joseph 704

Date signed 8-4-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED, WITH CONFIDENCE, IN ALL PLACES. PHYSICIANS: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06940
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 7:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

05942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 05942

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 5 - 1943

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/4/43

19

at 9⁰⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11/43 19 to 8/4/43 19 and that I last saw him alive on 19

Immediate cause of death

Acute lymphatic leukemia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 8/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

06943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06943

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 Aug 1 1943 and that I last saw her alive Aug 1 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

06944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06944
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 5 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 9¹⁵ M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1943 to Aug 3 1943, and that I last saw him alive on Aug 3 1943

Immediate cause of death

Carcinoma of Rectum

Duration

6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

06945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06945
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 611 E 33rd St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

AUG 5 - 1943

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.F.D. and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

6946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06946
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

(If less than one day)

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

AUG 5 - 1943

VB 160

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1939, to Aug. 3 1943, and that I last saw him alive on Aug. 3 1943.

Immediate cause of death

Cirrhosis of liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

86 York Court Date signed 8-3-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

6947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06947
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 402 E. 22nd St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 402 E. 22nd St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John W. Harrod

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Laura Harrod

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) April 7th 1856

8. AGE: Years

87

Months

3

Days

27

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

At home

11. Industry or business

Self

FATHER
MOTHER

12. Name

William T. Harrod

13. Birthplace

Md

14. Maiden Name

Ellen Spence

15. Birthplace

Md

16 (a) Informant

Ethel M. J. Harrod

(b) Address

402 E. 22nd St

17 (a)

Burial

(b) Date thereof

8/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Greenwood

Location

Chesapeake

18 (a) Funeral director

Williams & Son Inc

(b) Address

1217 St. Paul St.

AUG 5 1943
(Date rec'd by Registrar)(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 4th 1943, at 125

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/42 19 to 8/4/43 and that I last saw deceased alive on 8/1/43

Immediate cause of death

Due to

Myocardial Infarction

3 yrs

Due to

Arteriosclerosis

6 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. J. Williams

Address

1710 E. 23rd St

Date signed

8/4/43

06948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06948
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **813 S. BOND ST.**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **57 Y RS.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County **BALTO.**(c) City or town **BALTIMORE**
(If outside city or town limits, write RURAL and give town)(d) Street No. **813 S. BOND ST.**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

MARGARET B. RUND

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. **NONE**

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED6 (b) Name of husband or wife **CARL RUND**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **JAN. 21 1870**

8. AGE:

Years

Months

Days

If less than one day

73**6****11**

hr.

min.

9. Birthplace **GERMANY**

(Town, county, and state)

10. Usual Occupation **HOUSE WIFE**11. Industry or business **AT HOME**12. Name **JACOB ZEIGLER**13. Birthplace **GERMANY**14. Maiden Name **MARGARET**15. Birthplace **GERMANY**16 (a) Informant **CARL RUND (HUSBAND)**(b) Address **813 S. BOND ST.**17 (a) **BURIAL**

(Burial, cremation, or removal)

(b) Date thereof **AUG. 5/43**

(month) (day) (year)

(c) Cemetery or crematory **TRINITY**Location **ODONNELL ST.**18 (a) Funeral director **Leilly & Zeller, Inc.**(b) Address **403 S. WOLFE ST.****AUG 5 - 1943**

(Date received by Registrar)

(b) **Huntington Williams, M.D.**

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH **AUG. 2** 19 **43** at **5/30 M**21. I certify that death occurred on the date above stated; that I attended deceased from **Apr. 22** 19 **24** to **Aug 2** 19 **43**, and that I last saw him alive on **Aug. 2** 19 **43**.

Immediate cause of death

Uremic ComaDue to **Nephritis**

Due to

Other Conditions

Hypertension, Obesity, atherosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? **Yes** While at work? **Yes**
(Specify type of place)

(e) Means of injury

23. Signature **Harry Linder**Address **14 S. Bond St.** Date signed **8-4-43**

M. D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06949
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 251 S. REGISTER ST.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

3 (a) FULL NAME

FRANK J. SCHWEIGER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 215 07 3727

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife CATHERINE M. SCHWEIGER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 8 1893

8. AGE: Years Months Days If less than one day
49 9 26 25 hr. min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation GLAZER

11. Industry or business

12. Name VALENTIN SCHWEIGER

13. Birthplace BALTO. MD.

14. Maiden Name

15. Birthplace

16 (a) Informant CATHERINE M. SCHWEIGER (WIFE)

(b) Address 251 S. REGISTER ST.

17 (a) BURIAL (b) Date thereof AUG. 6/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Guler INC.

(b) Address 403 S. HOLME ST.

(Date rec'd by registrar)

(b) *Amstrong Williams, M.D.*
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 251 S. REGISTER ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH AUG. 5 1943, at 6/45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1943, to Aug. 3, 1943. that I last saw him alive on Aug. 4, 1943.

Immediate cause of death
Acute Myocardial Infarction
Due to Chl. Myocarditis +
Coronary Arteriosclerosis

Duration

acute

148 -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(a) Means of injury

23. Signature

Address

Date signed

9510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 302 S. Monroe St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 302 S. Monroe St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Paul Peter Flach

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-05-0192

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

Married

6 (b) Name of husband or wife Karoline Flach

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) April 10th, 1886

8. AGE: Years 57 Months 3 Days 24 hr. min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business Emerson Drug Co.

FATHER

12. Name Julius Flach

MOTHER

13. Birthplace Germany

14. Maiden Name Karoline Rensch

15. Birthplace

Germany

16 (a) Informant Mrs Karoline Flach

(b) Address 302 S. Monroe St

17 (a) Burial (b) Date thereof Aug 5th, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director F. B. Wippert & Son

(b) Address Baltimore & Monroe Sts

19 AUG 5 - 1943 (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3rd, 1943, 3.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1943, to Aug 3, 1943, and that I last saw him alive on Aug 1, 1943.

Immediate cause of death

Coronary thrombosis

Duration

Two

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Kermisch

Address 1934 W. ... Date signed 8/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(over)

06951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06951
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2619 Ariswell St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2619 Ariswell St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Charles A. Sumwalt Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Frances Sumwalt

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept. 3-1860

8. AGE:

Years

Months

Days

If less than one day

87

9

0

hr.

min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name Thomas Sumwalt

13. Birthplace

Germany

14. Maiden Name

unknown

15. Birthplace

unknown

16 (a) Informant Chas A. Sumwalt

(b) Address 2119 Ariswell St

17 (a) Burial (b) Date thereof 8-5-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

Baltimore

18 (a) Funeral director Leonard G. Rusk

(b) Address 5395 Harford Rd.

19 (a) AUG 5 - 1943 (Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1943 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1943 to Aug. 3 1943, and that I last saw him alive on Aug. 3 1943.

Immediate cause of death

Broncho Pneumonia

Due to Arteriosclerosis
1st infarction

Due to chronic bilateral nephritis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Mrs. F. A. Stroons

Address 2878 Harford Rd. Date signed 8 4 43

Duration
3d3d
7d

3d

6d

PHYSICIAN

Underline the cause to which death should be charged statistically.

6952

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06952

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *N. Broadway*

(c) Hospital or institution:

Church Home & Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10*(e) Length of stay in Baltimore (yrs., mos., or days) *46*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County(c) City or town *Baltimore MD*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4019 E. Men Ave.*

(If rural give location)

(e) Citizen of foreign country *European* (Yes or No)

If yes, name country

3 (a) FULL NAME

George Witter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Ida Witter*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb. 25, 1897*

8. AGE: Years Months Days If less than one day

*46**5**8*

hr.

min.

9. Birthplace *Baltimore, MD.*

(Town, county, and state)

10. Usual Occupation *Ship builder*

11. Industry or business

12. Name *George Witter*13. Birthplace *Maryland*14. Maiden Name *Mary Weller*15. Birthplace *Maryland*16 (a) Informant *Hospital Records*

(b) Address

17 (a) *Buried* (b) Date thereof *8-6-43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 5 - 1943

(b) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 3, 1943, at 9:00 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *July 25, 1943, to August 3, 1943,* and that I last saw him alive on *August 2, 1943.*

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions *Rheumatic Heart Disease**Cardiac Failure*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *George Witter*Address *Church Home & Hospital* Date signed *8/3/43*

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06953

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06953
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *20 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) *St. Louis* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *5226 Seneca Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Arthur Ross

3 (b) If veteran, name war

3 (c) Social Security Account

No. *212-18-0899*

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

31

hr.

min.

9. Birthplace

Caro Va.

(Town, county, and state)

10. Usual Occupation

Labrwr

11. Industry or business

FATHER

12. Name

William Ross

13. Birthplace

Virginia

14. Maiden Name

Blanche Thomas

15. Birthplace

Caro

16 (a) Informant

Mrs. L. Kaye Ross

(b) Address

5226 Seneca Ave.

17 (a)

(b) Date thereof

8-5-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *Bayce Va.*

18 (a) Funeral director

Archibald G. Gladwin

(b) Address

2401 M & E. Andrew St.

AUG 5 - 1943

(Date rec'd by registrar) *Washington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-1-* 19*43*, at *8:30* A. M.21. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *8/3/43* at *7:30 A. M.*(b) Where did injury occur? *3425 Paton Ave*(c) Did injury occur at home, on farm, industrial place, in public place? *Home* While at work? *No*(d) Means of injury *Struck on head with blunt object*23. Signature *Howard J. Wallace* M.D.Date signed *8-2-43*

06954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06954

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 638 W. Lombard Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 638 West Lombard St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Glenn R. McCann

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-22-4748

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Betty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1915

8. AGE:

Years

Months

Days

If less than one day

38

hr.

min.

9. Birthplace

North Carolina
(Town, county, and state)

10. Usual Occupation

Guard

11. Industry or business

12. Name

?

13. Birthplace

North Carolina

14. Maiden Name

?

15. Birthplace

North Carolina

16 (a) Informant

Betty McCann

(b) Address

638 W Lombard St.

17 (a)

Burial

(b) Date thereof

Aug 7 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

State Rd Cem.

Location

N. Carolina

18 (a) Funeral director

Joseph Kasinkas

(b) Address

602 Washington Ave.

19 (a)

(Date rec'd)

(b)

Wilmington

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1943, at M

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

occlusion

Coronary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on, farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert E. Gnatton M.D.

Medical Examiner

Date signed

August 4 1943

G 06955

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06955

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Cardine Hoffman St.*
 (c) Hospital or institution: *St. Joseph's Hosp*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *5*
 (e) Length of stay in Baltimore (yrs., mos., or days) *2*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *Baltimore*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *410 Patapsco Ave.*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Herman Greenstreet

3 (b) If veteran, name war

3 (c) Social Security Account
No. *213-10-0667*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife

Alorence W. Greenstreet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 26, 1900*

8. AGE: Years

42

Months

8

Days

9

If less than one day

*hr.**min.*

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

Motorman

11. Industry or business

Balto. Transit Co.

FATHER

12. Name

John W. Greenstreet

13. Birthplace

Va.

MOTHER

14. Maiden Name

Victoria Martin

15. Birthplace

Va.

16 (a) Informant

Mrs. Florence W. Greenstreet

(b) Address

410 Patapsco Ave

17 (a)

Burial

(b) Date thereof

Aug 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

3801 Frederick Ave.

18 (a) Funeral director

W. Howard Strong

(b) Address

3207 W. North Ave.

19 (a)

*AUG 5, 1943**Huntington, Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH

*August 4, 1943, at 12:00 M*21. I certify that death occurred on the date above stated; that I attended deceased from *July 31, 1943, to Aug 4, 1943.*that I last saw him alive on *Aug 4, 1943*

Immediate cause of death

*Post-operative**Coronary thrombosis*Due to *Coronary thrombosis*Due to *Coronary thrombosis*Other Conditions *Chronic**Cholelithiasis*

(Include pregnancy within 3 months of death)

Date of operation *Chronic*Major findings of operation: *Cholelithiasis*

of autopsy.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence *at* *M*
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? *While at work?*
 (Specify type of place)
 (e) Means of injury

23. Signature

*William Lusch*Address *St. Joseph's Hosp* Date signed *8/5/43*

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06956
Registered No.

G 06956

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 5 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3rd 1943 at 7¹⁵ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1943, to Aug 3 1943, and that I last saw him alive on Aug 3 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

4-5 yrs.

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

G 06957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06957

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 4 1943, at 7:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Aug 4 1943,

and that I last saw him alive on Aug 4 1943.

Immediate cause of death

Generalized Peritonitis

Due to Lymphosarcoma of peritoneum.

Due to Lymphosarcoma of bowel

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Generalized lymphosarcoma

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M/D

G 06958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06958

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Sarah Gilden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Joseph Gilden

7. Birth date of deceased (mo., day, yr.)

1865

8. AGE:

Years

Months

Days

If less than one day

78

hr.

min.

9. Birthplace

Austria

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Alexander Gilden

13. Birthplace

Austria

MOTHER

14. Maiden Name

Mirra -

15. Birthplace

Austria

16 (a) Informant

Mayer Gilden

(b) Address

Annapolis, Md.

17 (a)

Burial

(b) Date thereof

8-6-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rosedale

Location

Shanna Mishner

18 (a) Funeral director

Joe Lewis Inc

(b) Address

1431 E. Balt. St

19 (a)

(b) (Signature of registrar)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 5, 1943, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30, 1943, to Aug. 5, 1943, and that I last saw her alive on Aug. 5, 1943.

Immediate cause of death

Progressive Cerebral Thrombosis

Duration

Due to

Due to

Other Conditions

Diabetes Mellitus
Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert H. Jacobs

Address

Sinai Hospital

Date signed 8/5/43

M/D

AUG 5 - 1943

G 06959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06959

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 214-01-8171

4. Sex

5. Color of face

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 43, at 4:00 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 1/21/1943 to 8/4/1943

and that I last saw him alive on 8/4/1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is important

AUG 5 - 1943

G 06960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06960

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28/43 to 8/3/43 and that I last saw her alive on 8/3/43.

Immediate cause of death

Peripheral vascular disease

Due to amputation leg

Due to Sanguine leg

caused by embolus

Other Conditions: Diabetes mellitus

Arteriosclerotic C.V.D.

(Include pregnancy within 6 months of death)

Date of operation 8/2/43

Major findings of operations: embolus in popliteal artery

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 5 1943

VS 154

William C. Bradley, M.D.

G 06961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06961

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1400 N. Caroline St.*

(c) Hospital or institution:

St. Joseph's Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *30 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *3413 Mayfield Ln*
(If rural, give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced.*L*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

2dys - 6 hrs min.9. Birthplace *St. Joseph's Hospital*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Ernest William Street*13. Birthplace *Baltimore*14. Maiden Name *Dorothy Seacher*15. Birthplace *Baltimore*16 (a) Informant *Mr. B. Street*(b) Address *3413 Mayfield Ln*17 (a) *Burial* (b) Date thereof *8/5/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Cale Lawn*
Location *Southern Ave. Road.*18 (a) Funeral director *John A. Moran*(b) Address *3000 E. Baltimore St.*19 (a) *John A. Moran* (b) *Huntington Williams*
(Signature) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 3 1943* at *6:55* M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *8-3* 19*43*, to *8-5* 19*43*,
and that I last saw him alive on *8-5* 19*43*.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address *St. Joseph's* Date signed *8/5/43*
(over)

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

06962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06962
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *DON*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *518 N. Bond St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

*WALTER**ATKINS*

3 (b) If veteran, name war

3 (c) Social Security Account

No. *215-01-7985*

4. Sex

m

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Lillie ATKINS*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 17, 1893

8. AGE:

Years

Months

Days

If less than one day

*50**4**15*

hr.

min.

9. Birthplace

Charlottesville Co. Va

(Town, county, and state)

10. Usual Occupation

Longshoreman

11. Industry or business

FATHER

12. Name

James Atkins

13. Birthplace

Va.

MOTHER

14. Maiden Name

Ann?

15. Birthplace

16 (a) Informant

Lillie ATKINS

(b) Address

518 N. Bond St.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

8-3-43
(month, day, year)

(c) Cemetery or crematory

St. Mary's

Location

18 (a) Funeral director

Elroy Wilson

(b) Address

1000 E. Pratt St.

19 (a)

AUG 5 - 1943
(Date rec'd by registrar)*Walter Atkins*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 2, 1943, at 12:00 M*

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☒, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

drowning

Due to

Other Conditions *Laceration of scalp*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *8-1-43* at *3:45 P.M.*(b) Where did injury occur? *Purk. Jones Center*(c) Did injury occur at home, on farm, industrial place, in public place? *industrial* While at work? *yes*(d) Means of injury *struck by lumber end*23. Signature *M. J. W. Allen* M.D.Date signed *8-3-43* *knocked into water*

6963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06963

Registered No. 1108

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *865 W. Lexington*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ALFRED CHAMBERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

B

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

Baltimore

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

JULY 4, 1895

8. AGE:

Years

Months

Days

If less than one day

*48**-**29*

hr.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

FATHER
MOTHER

12. Name

WM CHAMBERS

13. Birthplace

MD.

14. Maiden Name

Mary Gardner

15. Birthplace

md.

16 (a) Informant

HANNAH CHAMBERS

(b) Address

865 W. LEXINGTON ST.

17 (a)

Burial

(b) Date thereof

7/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

ST. STEPHENS

Location

HOWARD CO. MD.

18 (a) Funeral director

ELROY WILSON

(b) Address

*1943 - 1945
BRANTLEY AVE*

19 (a)

1943 - 1945

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 3

1943, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 2* 1943, to *Aug 3* 1943, and that I last saw him alive on *Aug 3* 1943.

Immediate cause of death

*Toxemia
Respiratory Failure
Due to
Pneumonia
Pneumococcal Septicemia*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert J. Chenoweth

Address

*University Hosp.*Date signed *Aug 3, 1943*

6964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06964

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution:

Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

14 South Wolfe St

(If rural give location)

(e) Citizen of foreign country?

Yes or No

If yes, name country

3 (a) FULL NAME

Baby Kruger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

new born

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/11/43

8. AGE:

Years

Months

Days

If less than one day

6 hr. 0 min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Stanley Kruger

13. Birthplace

Allentown Pa

14. Maiden Name

Helen Kruger

15. Birthplace

Detroit Mich

16 (a) Informant

Helen Kruger

(b) Address

14 South Wolfe St

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 5 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19 AUG 5 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11 1943 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1943, to July 4 1943, and that I last saw him alive on July 11 1943.

Immediate cause of death

prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Helen L. Kruger

M.D.

Address

Sinai Hosp

Date signed

8/5/43

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

10276

06965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06965
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Don Secours Hosp 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. (a) FULL NAME

Baby Joseph A GRESTA

3 (b) Veteran, name war

3 (c) Social Security Account

4 Sex Male 5 Color or race White

6 (a) Single married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/3/43

8. AGE: Years Months Days If less than one day hr. 40 min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Neal A GRESTA

13. Birthplace Huntington Pa

14. Maiden Name Elizabeth Roman

15. Birthplace Pa

16 (a) Informant Neal A GRESTA

(b) Address 295 Balto County

17 (a) Burial (b) Date thereof 8/5/43

(c) Cemetery or crematory Cathedral

Location did not appear

18 (a) Funeral director

(b) Address 1801 Hollins St

19 (a) (b)

AUG 5 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Balto

(c) City or town Balto 295 Balto County

(If outside city or town limits, write RURAL and give town)

(d) Street No. Don Secours Hosp

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1943, at 8:09 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1943, to 8/3 1943 and that I last saw him alive on 8/3 1943

Immediate cause of death Congenital atelectasis

Due to Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at AM

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Raymond Boyer Date signed 8/3/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06966

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days) —

3 (a) FULL NAME

Baby James Moore

3 (b) If veteran, name war

3 (c) Social Security Account

No

4. Sex

Male

5. Color or race

White

6 (a) Single married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/14/43

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Mr. Robert F. Moore

13. Birthplace Newark, N. J.

14. Maiden Name Eugenia Wojcinski

15. Birthplace New York

16 (a) Informant Mr. Robert F. Moore

(b) Address Woodford, Md.

17 (a) Burial (b) Date thereof 8/15/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Old Woodford Rd

18 (a) Funeral director

(b) Address 1600 Hollins St

19 (a) AUG 5 - 1943

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Baltimore (b) County Dorchester

(c) City or town Woodford, Md.
(If outside city or town limits, write RURAL and give town)(d) Street No. Bon Secours Hosp
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1943, at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1943 to 8/14 1943 and that I last saw him alive on 8/14 1943.

Immediate cause of death

Congenital Atelectasis

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Lynwood Rye

Address Bon Secours Hosp

Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06967

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1120 E. Monument St.

(c) Hospital or institution:

Johns Hopkins Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(d) Street No. 1120 E.

(If outside city or town limits, write RURAL and give town)

Monument St.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Clara

Hancock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Frank Hancock

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.)

June 3 - 1880

8. AGE:

Years

Months

Days

If less than one day

63

2

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation

at Home

11. Industry or business

FATHER

12. Name

Calvin Ward

13. Birthplace

Safayette Ga.

MOTHER

14. Maiden Name

Estie Ward

15. Birthplace

Roxville Ga.

16 (a) Informant

Frank Hancock

(b) Address

1120 E. Monument St.

17 (a)

Burial

(b) Date thereof

Aug 6 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location Woodlawn Md.

18 (a) Funeral director

Ellsworth Amos

(b) Address

3911 Liberty Heights Ave

JUG 5 - 1943

Washington Williams, Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 3 1943, at 4⁵⁰ P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture

dislocation of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

August 3rd 1943 4 P.M.

(b) Where did injury occur?

1120 E. Monument St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury

Knocked down stairs

23. Signature

Robert L. Graham M.D.

Date signed

August 4 1943

G 06968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06968

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2804 Strathmore Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) life(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2804 Strathmore Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CAROLINE L. PENSEL

3 (b) If veteran, name war

3 (c) Social Security Account

No. ##

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed6 (b) Name of husband or wife Ferdinand A. Pensel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 18628. AGE: Years Months Days If less than one day
81 2 23 hr. min.9. Birthplace Balto., Md.
(Town, county, and state)10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Mr. Wm. F. Pensel(b) Address 2804 Strathmore Ave.17 (a) burial (b) Date thereof Aug. 7, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory BaltimoreLocation Balto., Md.18 (a) Funeral director Lassell Funeral Home(b) Address 7401 Belair Road19 (a) AUG 5 - 1943 (b)
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th 1943 8:15AM21. I certify that death occurred on the date above stated; that I attended deceased from Apr 14 1938 to Aug 5 1943 and that I last saw him alive on Aug 5 1943Immediate cause of death Cerebral HemorrhageDue to arterio sclerosis

Due to

Other Conditions Carcinoma Fibroid 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. [Signature]Address 3150 [Address]Date signed 8/5/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physician: please write the cause of death clearly and legibly.

06969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06969

Registered No. 83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1606 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-3

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1606 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Gaines B. Lockhart

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

M.

5. Color or race

C.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Annie L. Lockhart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 2-1891

8. AGE:

Years

Months

Days

If less than one day

62

2

1

hr.

min.

9. Birthplace

Ala.

(Town, county, and state)

10. Usual Occupation

Minister

11. Industry or business

FATHER

12. Name

William Lockhart

13. Birthplace

Ala.

14. Maiden Name

Petersen?

15. Birthplace

Ala.

16 (a) Informant

Annie L. Lockhart

(b) Address

1606 Edmondson Ave

17 (a)

Burial

(b) Date thereof

8-6-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

A.A. Co.

18 (a) Funeral director

Samuel W. Sullivan

(b) Address

177 N. Carrollton Ave

19 (a)

AUG 6 - 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1943, at 2:25 PM

21. I certify that death occurred on the date above stated, that I attended deceased from June 26 1943, to Aug 3 1943, and that I last saw him alive on Aug 2 1943

Immediate cause of death

Right Hemiplegia

Duration

Due to

Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. J. Coleman

Address

2039 McCulloch

Date

Aug 5 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06970
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Green St*

(c) Hospital or institution:

University

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2554 Frederick Ave.*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

*212-10-5699*6 (b) Name of husband or wife *Grace C. nee**Murphy*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 17, 1892*

8. AGE: Years

50

Months

11

Days

16

If less than one day

hr.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)10. Usual Occupation *Asst Foreman*11. Industry or business *E.T. Foreman Co.*12. Name *Sec. 14. John*13. Birthplace *Balto. Md.*14. Maiden Name *Mollie Carr*15. Birthplace *Balto. Md.*16 (a) Informant *Mrs. Charles F. John*(b) Address *2554 Frederick Ave.*17 (a) *Burial* (b) Date thereof *8-9-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *London Park*Location *Baltimore Maryland*18 (a) Funeral director *Harry H. Hitzke*(b) Address *4101 Blomondson Ave**Huntington Williams, Md*

AUG 6 - 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/3* 1943. *mid* *1200*21. I certify that death occurred on the date above stated; that I attended deceased from *7/27* 1943 to *8/3* 1943, and that I last saw him alive on *8/2* 1943.

Immediate cause of death

Medullary edema
Due to *Acute leukemia*
left -

Due to

Other Conditions *none*

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation

same
of autopsy: *same*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Ricard*Address *University Heights* Date signed *8/4/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06971

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Hickens Ave

(c) Hospital or institution:

St. Agnes Hospital 10-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7/29-8/4

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Balto

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1708 H. Lombard St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Louise M. Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 31, 1880

8. AGE: Years

73

Months

Days

3

If less than one day

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John Fox Armstrong

13. Birthplace

Canada

14. Maiden Name

Mary

15. Birthplace

France

16 (a) Informant

Vernon McTenny

(b) Address

7812 Colchester Rd

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8-7-43

(month) (day) (year)

(c) Cemetery or crematory

Hutten

Location

Baltimore Md.

18 (a) Funeral director

Harry H. Witzke

(b) Address

4401 E. Lombard Ave

19 (a) Date rec'd by registrar

AUG 6 - 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/4/43

1943, at P M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 7/29/1942 to 8/4/1943.

and that I last saw her alive on 8/4/1943.

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William J. Byers

Address

St. Agnes Hosp.

Date signed 8/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* Ward) *C*

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. *1311 Linden Ave* St. *11-4* Ward.

(Usual place of abode)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. Color or Race *W* 5. Single, Married, Widowed, or Divorced (write the word) *Widowed*6a. If married, widowed, or divorced (write the name of HUSBAND or WIFE) *Marie Konrad*6. DATE OF BIRTH (month, day, year) *9/3/88*7. AGE Years *54* Months *18* / Days *1* If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Machinist*9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Universal Machine*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Germany* (State or country)13. NAME *Julius C. Wisch*14. BIRTHPLACE (city or town) *Germany* (State or country)15. MAIDEN NAME *Natalie Simons*16. BIRTHPLACE (city or town) *Germany* (State or country)17. INFORMANT *Mr. Julius E. Wisch* (Address) *2227 S. A. St. Ave.*18. BURIAL, CREMATION, OR REMOVAL *Burial* Place *Western* Date *8-7* 197319. UNDERTAKER *Harry H. H. H.* (Address) *41018 Madison Ave.*20. DECEASED *AUG 6 - 1943* 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *8-4-43* 1922. I HEREBY CERTIFY, That I attended deceased from *4/2/43* 19 to *8/4/43* 19.I last saw him alive on *8/4/43* 19. Death is said to have occurred on the date stated above, at *11 P* m.

The principal cause of death and related causes of importance were as follows:

TBC of lung (X) & shunt.

Other contributory causes of importance:

Name of operation *Drainage of lung* Date of *4/4/43*What test confirmed diagnosis *not* Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify(Signed) *Earl M. Wilder* M. D.(Address) *2227 S. A. St. Ave.*

EARL M. WILDER - M.D.

G 66973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 66973
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof 8-6-43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) AUG 6 - 1943

(b) Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1943 to 8/3 1943, and that I last saw him alive on 8/3 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed 8/3/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06974
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Q. Hospital 1601

(d) Length of stay in hospital or inst. (yrs., mos., or days)

12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1213 Smithsonian St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Boy Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

♂

5. Color or race

colored

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/10/43

8. AGE: Years

Months

Days

If less than one day

10

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Kenneth Lonesome

13. Birthplace

Md

MOTHER

14. Maiden Name

Catherine Smith

15. Birthplace

Md

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 2 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

Huntington Williams, M.D.

AUG 6 1943

(Date recorded)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/20 1943 at 10:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/10 1943 to 7/20 1943

and that I last saw him alive on 7/20 1943

Immediate cause of death

Respiratory failure

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

David Wargaw

Address

Q. Hospital

Date signed

R. D.

G 66975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

832 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2940 Huntingdon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 12

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.

(d) Street No. 2940 Huntingdon Ave

(e) Citizen of foreign country? (If rural give location) (Yes or No)

If yes, name country

3 (a) FULL NAME

Clara B. Ball.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced.

Married.

6 (b) Name of husband or wife Adrian W. Ball

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1873

8. AGE: Years 69 Months 9 Days 22 hr. min.

9. Birthplace Maryland.

10. Usual Occupation Housewife.

11. Industry or business

12. Name Joseph C. Cooper.

13. Birthplace Maryland.

14. Maiden Name Susan Baker.

15. Birthplace Maryland.

16 (a) Informant Adrian W. Ball.

(b) Address 2940 Huntingdon Ave

17 (a) Burial (b) Date thereof Aug 6/43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory Middletown

Location Balto Co., Md.

18 (a) Funeral director Chenoweth & Sonoran

(b) Address 3615-17 Chestnut Ave

19 (a) by registrar

(b)

1943 Huntingdon William

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1943, 6:07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 43 to Aug 19 43, and that I last saw her alive on Aug 3 19 43.

Immediate cause of death

Cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edwin Glasman

Address 4037 Fell Rd. Date signed 8/5/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46H

G 06976

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2500 Garrison Blvd.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME

HENRY NATHANIEL SISCO

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Patience Bordeau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1879

8. AGE: Years 12 Months 10 Days 11 hr. min.

9. Birthplace Jay, Vt.

(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
MOTHER

12. Name Oliver S. Sisco

13. Birthplace Vt.

14. Maiden Name Mary J. Smith

15. Birthplace Vt.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 8/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory U.S. National

Location Arlington Va.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 AUG 6 1943

Read by

VB 154

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 4, 1943 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29, 1943, to Aug. 4, 1943, and that I last saw him alive on Aug. 4, 1943.

Immediate cause of death Retroperitoneal neuroblastoma, postop. & ra., residual; Inanition, marked

Duration
Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/4/43

Va-13492

G 06977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06977
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga Sts*

(c) Hospital or institution:

Mercy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*(e) Length of stay in Baltimore (yrs., mos., or days) *2 1/2 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore Md.*
(If outside city or town limits, write RURAL and give town)(d) Street No. *12 W. Hamburg*
(If rural give location)(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country

3. (a) FULL NAME

Mrs. Mary Wilson Roberts

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. *None*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Harry L. Roberts*6 (c) If alive, give age *20* years7. Birth date of deceased (mo., day, yr.) *May 18 1919*

8. AGE: Years Months Days

*67**2**5*

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

None

12. Name

William V. Elmore

13. Birthplace

Maryland

14. Maiden Name

Mary Wilson

15. Birthplace

*Maryland*16 (a) Informant *Harry L. Roberts*(b) Address *12 W. Hamburg*17 (a) *Cremation* (b) Date thereof *8/9/43*

(Burial, cremation, or removal)

(c) Cemetery or crematory

M. E. Church

Location

Rustington Md

18 (a) Funeral director

(b) Address

1217 N. Paul St

19 (a) (Date rec'd by registrar)

*August 6 - 1943**Wilmington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 5 1943* at *1:50 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 4 1943* to *Aug 5 1943* and that I last saw her alive on *Aug 5 1943*.

Immediate cause of death

*Cerebral hemorrhage*Due to *Hypertension*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: *Cerebral hemorrhage*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

*Robert F. Jones*Address *Mercy Hospital* Date signed *8/2/43*

Duration

11 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06978

MAWDe
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

06978
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 220-20-7012

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 7:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1943, to 8/5 1943,

and that I last saw her alive on 8/5 1943.

Immediate cause of death

Acute Pericardial Crystalline Failure

Due to Post Operative Paralytic Ileus

Due to

Other Conditions Rheumatic Cardio-vascular disease.

(Include pregnancy within 3 months of death)

Date of operation 8/2/43

Major findings of operation: Cholelithiasis

of autopsy: Paralytic Ileus.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Ben Leons 1111 St. Date signed 8/5/43

Duration

Chrs.

12 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 06979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06979
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Henry Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3226 Auchentoroly Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ALBERT H SCHLENNES SCHLEUNES3 (b) If veteran, name war
none3 (c) Social Security Account
No. none

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced.Single6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1895

8. AGE:

Years

Months

Days

If less than one day

48327

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Clerk Trucking Business

11. Industry or business

FATHER

12. Name Henry A. Schleunes13. Birthplace Germany

MOTHER

14. Maiden Name Julia Gauger15. Birthplace Germany16 (a) Informant E. E. Schleunes, Brother(b) Address 3226 Auchentoroly Terrace

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

8/7/43

(month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.Location Baltimore Md.18 (a) Funeral director M. J. TICKNER & SONS INC.(b) Address North & Pa Aves.

19 (a)

AUG 6 - 1943

(Date rec'd by registrar)

W. J. Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5, 1943 at 11:15 M

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Heart stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 8-4-43 at 11:15 M(b) Where did injury occur? Armed Hill & Fulton(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work? no(d) Means of injury Heart23. Signature H. J. Williams, M.D.Date signed 8-4-43 Medical Examiner.

06980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06980

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 37 N. Calvert St.
- (c) Hospital or institution: Union Memorial Hospital 12
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ind. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2826 St. Paul St.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MR. ROBERT EDWARD STEPHENS

3 (b) If veteran, name war

3 (c) Social Security Account

No. 576-05-3114

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. R.E. Stephens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1886

8. AGE:

Years

Months

Days

If less than one day

57310

hr.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

Hardware Cabinet

FATHER

12. Name

Mr. George Stephens

13. Birthplace

Baltimore Md

MOTHER

14. Maiden Name

Emma Louise Schnapke

15. Birthplace

Baltimore16 (a) Informant Mrs. Mary A. Stephens(b) Address 2826 St. Paul St.17 (a) Burial (b) Date thereof 8/7/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory LondonLocation Frederick Ave18 (a) Funeral director John J. Jackson & Sons(b) Address 6-19 North & B. Ave.19 (a) AUG 6 - 1943 (b) John J. Jackson & Sons
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1943, at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1943, to 8-4 1943, and that I last saw him alive on 8-4 1943.

Immediate cause of death

Primary tuberculosis

Duration

2 1/2 yrs.Due to Pulmonary tuberculosis15 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury

23. Signature John A. Presbit, Jr. M. D.
Address Union Memorial Hosp Date signed 8-4-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06981

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

MARGARET WILKINS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

4

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER
FATHER12. Name Unknown

13. Birthplace —

14. Maiden Name Elorence Wilkins15. Birthplace Virginia16 (a) Informant Elorence Wilkins(b) Address 1122 Brewer St.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8-6-43

(month) (day) (year)

(c) Cemetery or crematory Mt. AuburnLocation Baeto Md.18 (a) Funeral director William A. Jackson(b) Address 916 Penna Ave

19

AUG 6 - 1943Huntington Williams, Jr.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1122 Brewer Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1943, at M21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒, accident ☐, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Pneumonia lobular, primary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. A. Williams, Jr. M.D.

Medical Examiner

Date signed

G-6662

G-6662

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

10

(c) City Waller, Ore.
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 2906 Reisterstown Rd.

(e) Citizen of foreign country? no (Yes or No)

5 If yes, name country.....

MEDICAL CERTIFICATION

3 (c) Social Security Account

No. 22-000000

20. DATE OF DEATH May 1 1977, at 53

21. I certify that death occurred on the date above stated, that I attempted deceased from July 26 1943, to Aug 5 1943

and that I last saw him alive on Aug 5 1943.

Immediate cause of death.....	Duration.....
-------------------------------	---------------

Vanna

Due to Urinary retention

all in: look:

[illegible]

Other Conditions Arteriosclerosis

Arterial System PHYSICIAN

Date of operation..... Underline the

Major findings of operations: _____ cause to which death should be

of autonomy: charged station-
tially.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at.....

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

73. Signature *Harriet T. Jacobs*

Address: Sister: Mary Date signed: 3/1/80

Address 2000 1st St San Francisco Calif

PLEASE WRITE PENCIL, WITH UNFADING INK, ON ONE SIDE OF EACH CARD, IN ORDER TO BE EASILY REPRODUCED. Physicians: please write the causes of death clearly and legibly. correct age is especially important. correct age is especially important.

VOLUME 114

G 06984

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06984

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 5611 Magnolia Ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Katherine Reiter

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry Reiter

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1880

8. AGE: Years 62 Months 8 Days 21 If less than one day hr. min.

9. Birthplace Hungary

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name Henry Miller

13. Birthplace Hungary

14. Maiden Name Zeitzoval

15. Birthplace Hungary

16 (a) Informant Mr. Henry Reiter,

(b) Address 2611 Cold Spring Lane

17 (a) Burial (b) Date thereof 8/6/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross, A.A.Co.

Location A. A. County, Md.

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave.

19 (a) Date of death 10/4/43 (b) Registrar William M. R.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1943 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1943 to 8/3 1943, and that I last saw her alive on 8/2 1943.

Immediate cause of death

Carcinoma of breast
& metastasized to lungs
and abdomen

Duration

1 yr(?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 340 P N index Date signed 8/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

06985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 06985
Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 Plowman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Plowman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Vogel
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Feb. 25th 1937
8. AGE: Years Months Days If less than one day
6 5 8 10 11 hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Michael Vogel
13. Birthplace Baltimore Md.
MOTHER
14. Maiden Name Anna Larv
15. Birthplace Russia
16 (a) Informant Michael Vogel (Father)
(b) Address 811 Plowman St.

17 (a) Burial (b) Date thereof Aug. 7 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel 5712 O'Donnell
Location Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) August 8 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH August 5 1943 at 11¹⁰ AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were: IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury August 1 1943 3/2 M.
(b) Where did injury occur? On a lot at 288 S. Front St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Fell off of a (trailer) truck

23. Signature Robert E. Graham M.D.
Date signed August 5 1943
Medical Examiner

G 06986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06986

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1943 to Aug 4 1943, and that I last saw him alive on Aug 3 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 06987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06987
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 617 Super St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JUNE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

B

6 (a) Single, married, widowed, or
divorced. J

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

5

hr.

min.

9. Birthplace

(Town, county, and state) Md.

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

Hermit Brown

13. Birthplace

Charles Co. Md.

14. Maiden Name

Elizabeth Wells

15. Birthplace

16 (a) Informant

Elizabeth Brown

(b) Address

410 Little George St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 8/7/43
(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

Anne Arundel Co. Md.

18 (a) Funeral director

A. Halstead

(b) Address

918 Druid Hill Ave.

19 (a)

(Date rec'd by registrar)

Huntington Hill Ave., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1943 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 6-4 1943 to 8-1 1943.
and that I last saw her alive on 8-1 1943.Immediate cause of death Extensive
maternalis - liver & lung

Due to Wilms tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

S. W. Kominsky

Address

Univ. Hospital

Date signed

8-1-43

Deception

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 06988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06988

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
Mercy Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Barnes Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN HENRY YOUNG

3 (b) If veteran, name war

World War #1

3 (c) Social Security Account

No. 218-01-5998

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Separated

6 (b) Name of husband or wife Nannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1895

8. AGE: Years Months Days If less than one day

47 11 26 hr. min.9. Birthplace Fayetteville, N.C.

(Town, county, and state)

10. Usual Occupation Laborer11. Industry or business Capitol Lumber Co.12. Name Alexander Young13. Birthplace S.C.14. Maiden Name Julia McCoy15. Birthplace N.C.16 (a) Informant Julia Willis (Sister)(b) Address 1533 E. Monument St.17 (a) Burial (b) Date thereof Aug 6, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory Balto Nat Cem at Calvary Cn.Location D. C. County, Md.18 (a) Funeral director Robert L. Young(b) Address 8 X. Caroline St19 (a) Aug 6, 1943 (b) Robert L. Young

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1943 at 12:05 A. M

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull; Fractured ribs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury August 1, 1943 - 8 P.M. M(b) Where did injury occur? 3 N. Temple Street(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No(d) Means of injury Struck on head with an axe.23. Signature Howard J. Malden M.D.Date signed Per Robert L. Young MD
August 4, 1943

G 06989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 06989

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1943, to Aug 4, 1943.

and that I last saw him alive on Aug 3, 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 06930

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH

G 06990

Registered No.

61

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *University Ho.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4*(e) Length of stay in Baltimore (yrs., mos., or days) *life*

3 (a) FULL NAME

Mar grace Smith

3 (b) If veteran, name war

(c) Social Security Account No. *✓*

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, divorced

*married*6 (b) Name of husband or wife *R. Abbott Smith of*6 (c) If alive, give age *54* years7. Birth date of deceased (mo., day, yr.) *Feb 16, 1893*8. AGE: Years Months Days If less than one day
50 5 18 hr. min.9. Birthplace *Balto. Md.*
(Town, county, and state)10. Usual Occupation *home duties*

11. Industry or business

12. Name *Edwin Hebdern*13. Birthplace *Balto Md*14. Maiden Name *Winnie Hebdern*15. Birthplace *Balto Md*16 (a) Informant *Edwin R. Hebdern*(b) Address *Elberidge Md*17 (a) *Burial* (b) Date thereof *Aug 7/43*(c) Cemetery or crematorium *David Ridge*Location *Pikesville Md*18 (a) Funeral director *John O. Watchell*(b) Address *900 Eutaw Place*19 (a) *✓* (b) Registrar *Huntington Williams*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto*(c) City or town *Baltimore*

(If outside city or town limits, write R.U.R. and give town)

(d) Street No. *Middleborough Md*(e) Citizen of foreign country? *—* (If rural give location)If yes, name country *—* (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 4 1943* at *—* M21. I certify that death occurred on the date above stated; that I attended deceased from *8-1-1943* to *8-4-1943* and that I last saw her alive on *8-4-1943*Immediate cause of death *menia*

Duration

Due to *arteriosclerosis*Due to *hypertension*Other Conditions *Diabetes mellitus*

(Include pregnancy within 3 months of death)

Date of operation *none*Major findings of operations *—*of autopsy *—*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *—* at *—* M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury *—*23. Signature *Hepp J. Chenoweth*Address *Univ. Hosp.* Date signed *8/5/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

CONTACT: Age is extremely important. Please write the causes of death clearly and legibly.

UG 6 V8 100

G 06991

BALTIMORE CITY HEALTH DEPARTMENT

G 06991

CERTIFICATE OF DEATH

Registered No.

52N

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1943, to 8/5 1943, and that I last saw her alive on 8/5 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

JUG 6 1943

G 06992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G 06992

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: *University Hosp*(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME *John W. Boone*3 (b) If veteran, name war *World I.*3 (c) Social Security Account No. *216-050785*4. Sex *M.*5. Color of face *White*6 (a) Single, married, widowed, or divorced *Married*6 (b) Name of husband or wife *Katherine Boone*6 (c) If alive, give age *43* years7. Birth date of deceased (mo., day, yr.) *July 24 1893*8. AGE: Years *50* Months *0* Days *27* If less than one day9. Birthplace *Frederick Co. Md.*10. Usual Occupation *Mail Bright*

11. Industry or business

12. Name *Marshall Boone*13. Birthplace *Md.*14. Maiden Name *Josephine Wilson*15. Birthplace *Md.*16 (a) Informant *Mrs. Katherine Boone*(b) Address *4027 Fairview Ave*17 (a) *Removal* (b) Date thereof *Aug 7 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Unionville Md.*Location *Frederick Co. Md.*18 (a) Funeral director *Leech Funeral Home*(b) Address *2104-8, Orleans St*19 (a) *AUG 6 - 1943* (b) *William M. R.*

(Date rec'd by registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) *9 Md.* (b) County(c) City or town *Baltimore - Md.*

(If outside city or town limits, write R.U.R. and give town)

(d) Street No. *4027 Fairview Ave.*

(If rural give location)

(e) Citizen of foreign country? *Yes* (Yes or No)

If yes, name country

John W. Boone

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 4 1943* at *3 45* M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *8/4 1943* to *8/4 1943*and that I last saw him alive on *8/4 1943*Immediate cause of death *Crown Thrombosis*Duration *Immediate*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *J. C. ...*Address *University Hosp* Date signed *8/11/43*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 06993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06993
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(If rural give location)

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 3

1943

at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25 1942 to Aug 3 1943 and that I last saw him alive on Aug 3 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

66994

Social Security Account

HEALTH DEPARTMENT—CITY OF BALTIMORE

235-16-9532

CERTIFICATE OF DEATH

72B G 06994

1. PLACE OF DEATH

CITY OF BALTIMORE: (N *Franklin St.* St., *4* Ward)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

William B. Jennings

5014 Preston St. Baltimore, Md.

(a) Residence: No *Franklin St.* St.,

Ward *4*

(Usual place of abode)

(If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. Color or Race *W* 5. Single, ~~Married~~ Widowed, or divorced (write the word) *Married*

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of *Almeta M. Jennings*

6. DATE OF BIRTH (month, day, year) *Dec 6-1907*

7. AGE Years *35* Months *7* Days *30* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Inspector*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Glen R. Martin Co*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Luckey County* (State or country) *W. Va*

13. NAME *Samuel J. Jennings*

14. BIRTHPLACE (city or town) *W. Va* (State or country)

15. MAIDEN NAME *Dessie E. Gainer*

16. BIRTHPLACE (city or town) *W. Va* (State or country)

17. INFORMANT *Almeta M. Jennings* (Address) *5014 Preston St. Annapolis*

18. BURIAL, CREMATION, OR REMOVAL *Clarkburg St. R.* Place *Baltimore* Date *August 16, 1943*

19. UNDERTAKER *Robt C. B. M. Walter* (Address) *Pratt & Cluckers St.*

20. FILED *1943* 19 *Franklin St. Baltimore, Md.* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *August 5, 1943*

22. I HEREBY CERTIFY, That I attended deceased from *July 14, 1943* to *August 5, 1943*

I last saw him alive on *August 5, 1943* Death is said to have occurred on the date stated above, at *7:00 p.m.*

The principal cause of death and related causes of importance were as follows:

Hemaphysia

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury. 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Lain E. Davidson

(Address)

Franklin St. Baltimore, Md.

State causes of death in very important. See instructions on back of certificate.

AUG 6 - 1943

G 06995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 06995
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital 7-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1030 N. Wolfe
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Russell MARRINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

B

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15 1941

8. AGE: Years Months Days If less than one day

2 43 20 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation child

11. Industry or business

12. Name William Harriner

13. Birthplace Virginia

14. Maiden Name Helen Hightower

15. Birthplace Baltimore

16 (a) Informant hospital records

(b) Address

17 (a) Burial (b) Date thereof Aug 6 / 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cn

Location Grindel. St. J. M. H.

18 (a) Funeral director Mrs. R. H. Hightower's daughter

(b) Address 129 N. Caroline St

19 (a) (b) (Date rec'd by registrar) Registrar

AUG 6 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1943 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1943, to Aug 5 1943, and that I last saw him alive on Aug 5 1943.

Immediate cause of death

Adrenal hemorrhage, bilateral

Due to

Probable Septicemia

Due to

?? meningococcus

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Adrenal hemorrhage

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith

Address Sydenham Hos Date signed 8-6-43

Duration

few hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06996

BALTIMORE CITY HEALTH DEPARTMENT

G 06996

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2434 Francis St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Robert Hansen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 2, 1928

8. AGE:

Years

Months

Days

If less than one day

64

10

-1

hr.

min.

9. Birthplace

Baltimore, Md.

10. Usual Occupation

Porter

11. Industry or business

FATHER
MOTHER

12. Name

William Hansen

13. Birthplace

Maryland

14. Maiden Name

Clara Petersen

15. Birthplace

Maryland

16 (a) Informant

Emma Hansen

(b) Address

2434 Francis St.

17 (a)

Burial

(b) Date thereof

Aug. 7, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arbutus Green Ck.

Location

Baltimore Co., Md.

18 (a) Funeral director

Mr. Geo. H. Walla

(b) Address

1631 Druid Hill Ave.

19 (a)

(Date of registration)

August 10, 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2434 Francis St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 3, 1943

at 4 p.m.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 3/26/43 to 8/3/43

and that I last saw him alive on 8/3/43

Immediate cause of death

Cancer - Pericardial

Disease

Duration

1 yr.

Due to

Due to

Other Conditions

none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

15366 Lantana

Date signed

8/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 06997

CERTIFICATE OF DEATH

94a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Riggs Ave St. 6 Ward)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 16 da. How long in U. S. If of foreign birth? 30 yrs. 6 mos. 16 da.

2. FULL NAME

(a) Residence: No. 1216

(Usual place of abode)

Riggs Ave.

Ward 6

(If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

U. S. Veteran
specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. Color or Race colored 5. Single, Married, Widowed, or Divorced (write the word) married

6a. If married, widowed, or divorced
HUSBAND OF Caroline B. Nixon
(or) WIFE OF

6. DATE OF BIRTH (month, day, year) Feb 10, 1872

7. AGE Years 71 Months 5 Days 25 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Pullman Porter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) June, 1937

11. Total time (years) spent in this occupation 25 yrs.

12. BIRTHPLACE (city or town) Huntsville
(State or country) North Carolina

13. NAME John D. Nixon

14. BIRTHPLACE (city or town) Huntsville
(State or country) North Carolina

15. MAIDEN NAME Ellen Lusher

16. BIRTHPLACE (city or town) Huntsville
(State or country) North Carolina

17. INFORMANT Caroline B. Nixon
(Address) 1216 Riggs Ave

18. BURIAL, CREMATION, OR REMOVAL

Place St. Ambrose Date Aug 2, 1943

19. UNDERTAKER Mr. George W. Hall
(Address) 1631 1st St. S.E.

20. DEATH AUG 6 - 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 5, 1943

22. I HEREBY CERTIFY, That I attended deceased from April 4, 1938 to Aug 5, 1943

I last saw him alive on Aug 4, 1943 Death is said to have occurred on the date stated above, 10:55 a.m.

The principal cause of death and related causes of importance were as follows:

Coronary disease of heart

Date of onset

4-15-38

Other contributory causes of importance:

arteriosclerosis

5 yrs.

Was an operation performed? no Date of

For what disease or injury?

Name of operation physical signs & symptoms

What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John S. J. Campbell M. D.

(Address) 639 N. Carey St., Balto.

Huntington Williams, M.D.

98432/88

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06998

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ma** (b) County(c) City or town **Thomson**
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife **William**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **2-7-98**

8. AGE: Years Months Days If less than one day

-45 5 29 hr. min.9. Birthplace **Ma**
(Town, county, and state)10. Usual Occupation **Housewife**

11. Industry or business

12. Name **Jim Hinton**13. Birthplace **Ma**14. Maiden Name **Alice Hammish**

15. Birthplace

16 (a) Informant **Residence**
(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **Aug 9/43**
(Burial, cremation, or removal) (month) day (year)(c) Cemetery or crematory **Thomson**
Location **Ma**18 (a) Funeral director **John P. Mitchell**(b) Address **1900 Eutaw Place****AUG 6 1943** **Huntington Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 6 1943** **9-41**21. I certify that death occurred on the date above stated; that I attended deceased from **March 29, 1943** to **Aug 6 1943** and that I last saw her alive on **Aug 6 1943**.Immediate cause of death **Heart Failure**

Duration

Due to **Emphysema**Due to **operation for removal of ca of esophagus**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **July 9, 1943**Major findings of operation: **ca of esophagus, inoperable.**

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **J. H. A.**Address **J. H. A.** Date signed **8/6/43**

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 06999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 06999

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 213 W. Mulberry St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Leong Cheek

32886

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Chinese

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1897

8. AGE: Years Months Days If less than one day

55

10

24

?

hr.

min.

9. Birthplace

? (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

Wong ?

15. Birthplace

China

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 8-9-43 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 19 43 4:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 19 43, to Aug. 4 19 43, and that I last saw him alive on Aug. 4 19 43.

Immediate cause of death

Pulmonary tuberculosis

Duration

1 yr?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul Hett

Address

B.C.C.

Date signed

8/1/43

PLEASE WRITE IN INK. Physicians: please write the cause of death in plain English. correct age is especially important.

VB 126

G 07000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of registration

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from July 1940, to Aug 5, 1943.

and that I last saw her live on Aug 5, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1403 Park Ave Date signed 8/5/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G 07001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07001

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1943, at 10:30 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Date signed

Medical Examiner

M.D.

G 07002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07002

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1631 Normal Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

*JOSEPH**SCHOENIG*

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

*w*6 (a) Single, married, widowed, or
divorced6 (b) Name of husband or wife *Annie Schoenig*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 6th 1876*

8. AGE: Years Months Days If less than one day

66 66 79 28 hr. min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name

Joseph Schoenig

13. Birthplace

Md.

MOTHER

14. Maiden Name

Miller

15. Birthplace

Md.

16 (a) Informant

Margaret Colburn(b) Address *1640 Normal Ave*17 (a) *Burial* (b) Date thereof *8/7/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or place of interment *Holy Redeemer*Location *Balto Md.*18 (a) Funeral director *William Cook Inc*(b) Address *1217 St. Paul St**August 7 - 1943* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 4 1943 at 3:25 PM*

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur? _____

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury _____

23. Signature *H. Z. Wollmerster* M.D.Date signed *8-5-43* Medical Examiner.

The information on this certificate is to be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 07003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07003
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1229 N Washington St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *8*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give location)

(d) Street No. *1229 N Washington St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME *William E Thomas*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex *Male*

5 Color or race *White*

6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband or wife *Dorothy*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec 20, 1882*

8. AGE: Years *60* Months *7* Days *9* If less than one day hr. min.

9. Birthplace *Queens York*

10. Usual Occupation *Carpenter*

11. Industry or business *Mr Engle*

12. Name *Unknown*

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *Dorothy Thomas*

(b) Address *1229 N Washington St*

17 (a) *Burial* (b) Date thereof *8/9/43*

(c) Cemetery or crematorium *Mount Vernon*

Location *Baltimore Md*

18 (a) Funeral director *Thomas & Son*

(b) Address *1229 N Washington St*

(c) Telephone No. *213-1111*

(d) Signature *William E Thomas*

(e) Address *1229 N Washington St*

(f) Signature *William E Thomas*

(g) Address *1229 N Washington St*

(h) Signature *William E Thomas*

(i) Address *1229 N Washington St*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 4* 1943. at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 23* 1943. to *Aug 4* 1943. and that I last saw him alive on *Aug 2* 1943.

Immediate cause of death

Valvular Heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Jacob Fisher*

Address *1823 N. Main St* Date signed *8/1/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 2 1943

G 07004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07004
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2700 N. Howard St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

12

(e) Length of stay in Baltimore (yrs., mos., or days)

Left

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2700 N. Howard St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Edward Parr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Aug 22nd 1942

8. AGE:

Years

Months

Days

If less than one day

11

13

12

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Wm Henry Parr

13. Birthplace

Balto. Md.

14. Maiden Name

Ether Bostwick

15. Birthplace

Balto. Md.

16 (a) Informant

William Henry Parr

(b) Address

2700 N. Howard St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Dund Ridge

Location

Kensville Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (c) Date of registration

Aug 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 5th 1943 5:15 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2nd 1943 to Aug 5th 1943, and that I last saw him alive on Aug 5th 1943.

Immediate cause of death

Pneumonia Congestive

Due to

Myocardial Infarction

Due to

Pulmonary Stenosis
Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George J. Rayley

Address

Kensville Md.

Date signed

8/6/43

The age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07005
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. Since June 16, 1943 (yrs., mos., or days)

(e) Length of stay in Baltimore Since June 16, 1943 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State R.I.

(b) County

(c) City or town Providence

(If outside city or town limits, write RURAL and give town)

(d) Street No. 121 Chestnut St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME RAYMOND ARTHUR SWAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dorothy Maynard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 21, 1890

8. AGE: Years 53 Months 6 Days 15 If less than one day hr min.

9. Birthplace Kittery, Maine

(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business U.S.E.C.

12. Name Charles Swain

13. Birthplace Kittery, Maine

14. Maiden Name Harriet T. Trefou

15. Birthplace Kittery, Maine

16 (a) Informant Records, U.S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 8 7 43 (month/day/year)

Location St. Mary's Hospital, Providence, R.I.

18 (a) Funeral director A. C. Elder

(b) Address 46 44 York Rd. AUG 7 - 1943 (Date rec'd by registrar) (c) Minister William M. A.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Aug. 5, 1943 at 6:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16, 1943 to Aug. 5, 1943, and that I last saw him alive on Aug. 5, 1943.

Immediate cause of death Broncho-pneumonia, bilateral

Duration 6 days

Due to Bronchiogenic carcinoma, right main bronchus

Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/20/43-Bronchoscopy

Major findings of operations Carcinoma

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury L.S. 13, 14

23. Signature L.S. 13, 14

Address Baltimore, Md.

Date signed 8/5/43

G 07006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07006

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2803 Garrison Blvd.

(c) Hospital or institution:

Garrison Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3464 Chessel Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lucy L. Gill

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Harold A. Gill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1898

8. AGE: Years Months Days If less than one day
65 4 2 hr. min.

9. Birthplace France

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace France

14. Maiden Name Unknown

15. Birthplace France

16 (a) Informant Mr. Harold A. Gill

(b) Address 3464 Chessel Court

17 (a) Burial (b) Date thereof Aug 7, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Olivet
Location Frederick Road Baltimore Md.

18 (a) Funeral director Wm. J. Tickner & Sons,

(b) Address North & Pa. Aves.

19 (a) AUG 7 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5, 1943 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1943, to Aug 5, 1943, and that I last saw him alive on Aug 5, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Rubin M. D.

203 Calverton Date signed

correct age is especially important. Physicians, public health officers, and registry.

G 07007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07007

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2613 Penna. Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State md, (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2613 Penna. Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Byerly Hesse

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. 219-05-6593

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Hesse6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.)

Jan 10 - 1864

8. AGE: Years

79

Months

6

Days

26

If less than one day

hr.

min.

9. Birthplace

Baltimore md.

10. Usual Occupation

Retired Shipping Dept.

11. Industry or business

U.S. Navy

12. Name

William Hesse

13. Birthplace

Drux Run

14. Maiden Name

Mary Cynky

15. Birthplace

Drux Run

16 (a) Informant

Mrs. Barbara Hesse

(b) Address

2613 Penna. Ave.17 (a) Burial(b) Date thereof Aug 9 1943

(c) Cemetery or crematory

Woodlawn

Location

Balt & Co. Md.

18 (a) Funeral director

Wm. J. Ticken

(b) Address

1663 W. North Ave.

19 (a) (b)

(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1943, at 3:50 P.21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Aug 5 1943, and that I last saw him alive on Aug 5 1943

Immediate cause of death

Chr. Myocarditis

Due to

Chr. Interstitial

Due to

myocarditis

Other Conditions

Astero Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature Paul BrownAddress 1663 W. North Ave.Date signed 8/5/43

Duration

1938

G 07008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07008
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)(d) Street No. Fairfield Trailer Camp.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John A. Strickland

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Vayda

6 (c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) 11-18-01

8. AGE:

Years

Months

Days

If less than one day

4142816

hr.

min.

9. Birthplace

n.c.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Frank Strickland

13. Birthplace

n.c.

14. Maiden Name

Leona Parker

15. Birthplace

n.c.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/7/43

(month) (day) (year)

(c) Cemetery or crematory

Moreland Pk.

Location

Baltimore, Md.

18 (a) Funeral director

Oswald A. Coirington

(b) Address

21 W. 25th St. Baltimore, Md.

19 (a) AUG 7 - 1943

(b) (Signature of registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1943 at 9:40 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1943 Aug. 4 1943 and that I last saw him alive on Aug. 4 1943.

Immediate cause of death

! Coronary OcclusionDue to Thrombotic coronary arteryDue to Anterior wall coronary arteryOther Conditions Angina pectoris

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert Day

Address Johns Hopkins HospitalDate signed 8/9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07009

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland

(b) County

(c) City or town Crisfield

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

WILLIAM RAYFIELD

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Emma Ward

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 11, 1870

8. AGE: Years Months Days If less than one day

73

0

25

hr.

min.

9. Birthplace Crisfield, Maryland

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Wm. Rayfield

13. Birthplace Crisfield, Md.

14. Maiden Name Isador Ward

15. Birthplace Crisfield, Md.

16 (a) Informant Records, U.S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 8/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Crisfield Md.

18 (c) Funeral director Edward A. Corington

(b) Address 21 W. 25th St

19 (a) AUG 7 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Address Baltimore, Md.

Date signed 8/5/43

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Aug. 5, 1943, at 10:05M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29, 1943, to Aug. 5, 1943, and that I last saw him alive on Aug. 5, 1943.

Immediate cause of death.

Uremia

Duration

Unk.

Due to

Due to

Other Conditions Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide. No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury L.S. Train

23. Signature

L.S. Train

M. D.

Address Baltimore, Md.

Date signed 8/5/43

G 07010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07010
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 210 Silver Court
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

SUSIE

MACK

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife

George Mack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

55

54

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Jack Jenkins

13. Birthplace

Georgia

14. Maiden Name

Mattie Dorsey

15. Birthplace

Georgia

16 (a) Informant

Mack Smith

(b) Address

631 W. Franklin St.

17 (a) Burial

(b) Date thereof

Aug 9 - 43

(Burial, cremation, or removal)

(month day year)

(c) Cemetery or crematory

Auburn Memorial

Location

Auburn md

18 (a) Funeral director

Robert Williams

(b) Address

1515 N. Eldred St

19 (a) Registered by registrar

(b) Huntington Williams

VN 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1943 at 4:30 M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cervical occlusion

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature H. Z. Wallenweber M.D.Date signed 8-4-43

Medical Examiner.

G 07011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07011

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 3410 Doelfield ave.
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3410 Doelfield ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

William Frederick Eierman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Mary Eierman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1859

8. AGE: Years 85 Months 8 Days 11 9 hr. min.

9. Birthplace Germany
(Town, county, and state)10. Usual Occupation Baker

11. Industry or business

12. Name John G. Eierman13. Birthplace Germany14. Maiden Name Julia Streib15. Birthplace Germany16 (a) Informant Mrs. Anna M. Lewis(b) Address 3410 Doelfield Ave.17 (a) Burial (b) Date thereof Aug. 7, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore
Location Baltimore city18 (a) Funeral director Ullrich Funeral Home(b) Address 2004-2008 Orleans St.19 (a) 1943 Hunting for William Eierman Address 4 N. Fallm Date signed 8/5

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1943 19 43 at 8:15 AM21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 43 to Aug 5 19 43, and that I last saw him alive on Aug 1 19 43.

Immediate cause of death

Carcinoma of right maxillary antrum.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 4 N. Fallm Date signed 8/5

Duration

6 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07012
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Stellman Ave*

(c) Hospital or institution:

St. Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Samuel J. Davis

3 (b) If veteran, name war

3 (c) Social Security Account
No. *None*

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced.*Widowed*

6 (b) Name of husband or wife

Ethel M. Henry

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Aug. 26th 1882*

8. AGE:

Years

Months

Days

Less than one day

*60**11**10**hr.**min.*

9. Birthplace

Maryland

10. Usual Occupation

Coach Painter

11. Industry or business

MOTHER

12. Name

Jesse (dec'd)

13. Birthplace

Unknown

14. Maiden Name

Martha Brady

15. Birthplace

*Va.**(dec'd)*

16 (a) Informant

Mrs. Trocher

(b) Address

Raspburg, Box 381

17 (a)

Burial

(b) Date thereof

Aug. 9 43

(Burial, cremation, or removal)

(c)

Cemetery or crematorium

Jones Memorial

Location

Belair, Maryland

18 (a) Funeral director

Chas. H. Palmer

(b) Address

7401 Belair Road

19 (a)

(b)

*AUG 7 - 1943**Registrar*

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Raspburg, P.D. #2

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Box 381

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 6th 1943*, at *1 a.m.*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 5 1943* to *Aug 6 1943*, and that I last saw him alive on *Aug 6 1943*

Immediate cause of death

Tubercular pneumonia

Due to

Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

tb. pneumonia - bronchial

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Alfred H. Hanson

Address

St. Agnes Hosp

Date signed

8-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically

G 07013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07013

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw h

alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place?

(e) Means of injury

23. Signature

Address

Duration

9

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE PRINT NAME OF PHYSICIAN IN FULL. PHYSICIAN'S SIGNATURE AND ADDRESS MUST BE SUBMITTED WITH THIS CERTIFICATE. CORRECT AGE IS ESPECIALLY IMPORTANT.

07014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07014
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address:

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

UNIDENTIFIED

COLORED MALE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

col

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

50

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY AUG 7 1943

18 (a) Funeral director

(b) Address

AUG 7 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1943 at 6:00 M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

at July 1943 3/2 M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

J. Z. Williams, M.D.

Date signed

7-23-43

Medical Examiner.

G 07015

MJ-75231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137

G 07015

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr., 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1713 Etting Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Shadrick Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife Etta Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1879

8. AGE: Years Month Days If less than one day

63

9

13

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Daniel Dorsey

13. Birthplace Maryland

14. Maiden Name Mary Jones

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Journal (b) Date thereof 8/7/43

(Burial, cremation, or removal)

(c) Cemetery or crematorium Mt Auburn

Location

18 (a) Funeral director H. H. Nelson

(b) Address 1303 Pressman

19 (a) AUG 7 1943

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1943 at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 7/29 1943, and that I last saw him alive on 7/29 1943.

Immediate cause of death

cardiac failure; as a result of coronary artery disease

Due to

Other Conditions TBC (?)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sargman

Address ACH Date signed 7/31

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07016

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1144 N. Calhoun St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1144 N. Calhoun St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES

JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

COL

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Ernestine Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 18808. AGE: Years Months Days If less than one day
62 7 21 hr. min.9. Birthplace Ind.
(Town, county, and state)10. Usual Occupation None

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant E. Elizabeth Taylor(b) Address 1144 N. Calhoun St17 (a) Burial (b) Date thereof 8/9/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Int. Auburn
Location Ind.18 (a) Funeral director Reg. S. Kelson(b) Address 1303 Presiding(c) Huntington HillDate received by Registrar Aug 7 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1943 at 6 P.M.21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. WollamDate signed 8-7-43 Medical Examiner.

G 07017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07017
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4903 Crowson Ave.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4903 Crowson Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Nannie L'Allemand

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 12/17/67

8. AGE:

Years 75

Months 7

Days 18

If less than one day

hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Charles L'Allemand

13. Birthplace Germany

14. Maiden Name Emelie Muehler

15. Birthplace Germany

16 (a) Informant Miss Claire L'Allemand

(b) Address 4903 Crowson Ave.

17 (a) Burial (b) Date thereof 8/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore, Md.

18 (a) Funeral director H.W. Moore & Son

(b) Address 805 N. Calvert St.

AUG 7 - 1943

(b) Huntington Williams, M.D.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1943 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Aug. 5 1943, and that I last saw her alive on Aug 5 1943.

Immediate cause of death Cerebral Thrombosis

Duration 7 weeks

Due to Arteriosclerosis, severe

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R.H.B. Wright

Address Medical Arts Bldg. Date signed 8/6/43

07018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07018

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1909 Boone St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY

TWELE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1870

8. AGE:

Years

Months

Days

If less than one day

73

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Frederick Twelle

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 7 - 1943

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1943 at 1:55 PM21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis
cardiovascular disease

Due to

Other Conditions

Fracture of left
humerus
(Include pregnancy within 3 months of death)22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 7-15-43 (app.) 9/8 M.(b) Where did injury occur? home(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? no(d) Means of injury fell down steps of home23. Signature H. W. Wallenmeyer M.D.Date signed 8-7-43 Medical Examiner.

PLEASE WRITE PRINTED NAME AND ADDRESS OF PHYSICIAN OR NURSE WHO ATTENDED DECEASED. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

207019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 207019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Wilmington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Wilmington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Virginia Voyce

3 (b) If veteran, name war No 3 (c) Social Security Account No

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas J. Voyce 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1887

8. AGE: Years 56 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Kemp Hooper 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Frances Reese 15. Birthplace Baltimore, Maryland

16 (a) Informant Adele Pettit (b) Address 1804 Wilmington Avenue

17 (a) Burial (b) Date thereof Aug. 10, 1943 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Location Balto, Co. Maryland

18 (a) Funeral director George L. Schwab (b) Address 2101 Frederick Avenue

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1940, to Aug. 6, 1943, and that I last saw her alive on Aug. 5, 1943.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature 3030 Edmondson Ave. Date signed 8/7/43

Address Date signed

Duration 3 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

AUG 8 1943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Social Security 215-18-1471

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Light*)

Length of residence in city or town where death occurred

2. FULL NAME

(a) Residence: No. *2545*

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. Color *White* 5. Single, Married, Widowed, or Divorced (write the word) *Married*6a. If married, widowed, or divorced HUSBAND of (or) WIFE of *Married*6. DATE OF BIRTH (month, day, year) *August 21-1883*7. AGE Years *59* Months *11* Days *26* If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Produce Dealer*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Self*
10. Date deceased last worked at this occupation (month and year)12. BIRTHPLACE (city or town) *Baltimore Md.* (State or country)13. NAME *Irvin LeRoy Frey*
14. BIRTHPLACE (city or town) *Mayland* (State or country)15. MAIDEN NAME *Lula Hengch*
16. BIRTHPLACE (city or town) *Maryland* (State or country)17. INFORMANT *Augusta Frey* (Address) *2545 Frederick Ave*18. BURIAL, CREMATION, OR REMOVAL Place *Lorraine Park* Date *August 9th 1943*19. UNDERTAKER *George L. Schrock* (Address) *2104 Frederick Ave*20. *1943* 19 *8* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *Aug. 6* 19*43*22. I HEREBY CERTIFY, That I attended deceased from *1930* to *6 Aug* 19*43*I last saw him alive on *6 Aug* 19*43* Death is said to have occurred on the date stated above, at *md.*

The principal cause of death and related causes of importance were as follows:

Intestinal Obst

Date of onset

4 mos ago

Other contributory causes of importance:

*Intestinal Obstruction**1931*

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

MJ-83083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **BALTIMORE CITY HOSPITALS**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **1 day**
(e) Length of stay in Baltimore (yrs., mos., or days) **?**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** County **Washington DC**
(c) City or town **Washington DC**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **4613 38th St.**
(If rural give location)
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country

3 (a) FULL NAME

Leo Byrl Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **45?**
8. AGE: Years **45?** Months **?** Days **?** If less than one day, hr. **18** min. **48**

9. Birthplace **?**

(Town, county, and state)

10. Usual Occupation **?**

11. Industry or business

12. Name **?**
13. Birthplace **?**
14. Maiden Name **?**
15. Birthplace **?**

16 (a) Informant **BALTIMORE CITY HOSPITALS**

(b) Address **(RECORDS)**

17 (a) (b) Date thereof

(c) Cemetery or crematory **Murphy Cemetery**
Location **Murphy, Indiana**

18 (a) Funeral director **Martin W. Brown**

(b) Address **1300 N. St. N. W. Wash. D.C.**

19 (a) **8-1943** (b)

(Date rec'd by registrar) Registrar **Huntington Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **8/6 1943**

21. I certify that death occurred on the date above stated; that I attended deceased from **8/6 1943** and that I last saw him alive on **8/6 1943**.

Immediate cause of death **Cerebral hemorrhage**
pos. arteriovenous aneurysm
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence **at M**
(c) Where did injury occur? **(City or town) (County) (State)**

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**
(Specify type of place)

(e) Means of injury

Signature **E. L. Seymour**
Address **B. C. H.** Date signed **8/7/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07022
1798 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

116SExeterSt.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mildred M. Rose

3 (b) If veteran, name war

N—

3 (c) Social Security Account

No. None

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Frank6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

Nov. 29/1893

8. AGE:

Years

Months

Days

If less than one day

4986

hr.

min.

9. Birthplace

Boston, Mass.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

?Forrest

13. Birthplace

?

MOTHER

14. Maiden Name

?

15. Birthplace

Mass.

16 (a) Informant

Frank Rose

(b) Address

116 S. Exeter St.

17 (a)

burial

(Burial, cremation, or removal)

(b) Date thereof

8/9/43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd.

18 (a) Funeral director

M. W. F. Dippel's Sons

(b) Address

Lombard & Ann St.

19 (a)

(Date for filing)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1943, at 5³⁰ PM

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☒ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Poisoning due to barbiturate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury August 4 1943 5 P.M.(b) Where did injury occur? 116 S. Exeter St.

(c) Did injury occur at home, on farm, industrial place, in public

place? homeWhile at work? no(d) Means of injury Ingestion of barbiturate23. Signature Robert Lee Grady M.D.Date signed August 6 1943

G 07023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07023

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *freemanspring & Belvedere*

(c) Hospital or institution:

Hebrew Home for Aged & Infirmed(d) Length of stay in hospital or inst. (yrs., mos., or days) *15 months*(e) Length of stay in Baltimore (yrs., mos., or days) *40 Yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *freemanspring & Belvedere*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Max Pressman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

*white*6 (a) Single, married, widowed, or divorced.*married*

6 (b) Name of husband or wife

Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 7, 1875

8. AGE: Years

68

Months

1

Days

29

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

*Merchant Retiree*FATHER
MOTHER12. Name *Usher Pressman*

13. Birthplace

Russia

14. Maiden Name

Freidel Pressman

15. Birthplace

Russia

16 (a) Informant

Mrs Pearl Pressman(b) Address *Levindale Home*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Aug, 8, 1943*

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Rosedale

Location

Hamilton Ave

18 (a) Funeral director

Sol Levinson & Bros(b) Address *1124 1126 W North Ave*

19 (a) Date of death

August 6, 1943

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 6, 1943 at 5 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *5/22/1943* to *8/6/1943*.and that I last saw him alive on *8/6/1943*.Immediate cause of death *Ch. card. ov. disease*

Duration

Due to

Due to

Other Conditions *Complete heart block*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Edmund L. Levin*Address *Levindale*Date signed *8/6/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

607024
607023BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937607024
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greenpring & Belvedere Ave

(c) Hospital or institution:

Melrose Home for Aged & Infirmed(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs(e) Length of stay in Baltimore (yrs., mos., or days) 6 5/16

3 (a) FULL NAME

Isaac I. Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Ray H. Levin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

70

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Arthur A. Levin

13. Birthplace

14. Maiden Name

Feldie

15. Birthplace

Russia

16 (a) Informant

Mrs. Sybil Cohen

(b) Address

3330 Sunbelt Ave

17 (a)

Burial

(Burial, cremation, or reinterment)

(b) Date thereof

8-8-43

(c) Cemetery or crematory

B'nai Israel

Location

Northman Ave.

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Balto St

Date of death

Aug 8, 1943

Date of registration

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Greenpring & Belvedere Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1943 at 2 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from 8-8-1941 to 8-6-1943 and that I last saw him alive on 8-6-1943Immediate cause of death Ch. card. vas. disease

Duration

Due to Parasitosis Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Edmund & Levin M.D.

Address

Levendale

Date signed

8/6/43

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Lanham & Green*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 mos*

(e) Length of stay in Baltimore (yrs., mos., or days) *56 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *708 E North Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Francis Louis Boll

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. *5-1-10*

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male White

Married

6 (b) Name of husband or wife

Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 20 1869

8. AGE: Years Months Days

94 4 19

If less than one day

hr. min.

9. Birthplace

Baltimore & MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John & Mazon

13. Birthplace

14. Maiden Name

Elizabeth Kueger

15. Birthplace

France

16 (a) Informant

Harry R. Boll

(b) Address

708 E North Ave

(c) Date thereof

8/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Greenwood

18 (a) Funeral director

(b) Address

1217 E. Pratt St

AUG 8 - 1943

(Date rec'd by Registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 7 1943 3:05 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *June 2 1943* to *Aug 7 1943* and that I last saw him alive on *Aug 3 1943*

Immediate cause of death

Pericardial effusion

Duration

Due to

Pericardial effusion(?)

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *James W. Byrnes*

Address *Univ. Hospital*

Date signed *8/7/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date

(b) Signature

(Date rec'd by Registrar)

(Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 99 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1937 to 8/7 1943, and that I last saw her alive on 8/6 1943.

Immediate cause of death

Coronary Thrombosis

Duration 2 hrs.

Due to Anteriorapartia Cordis. Vascular Disease

Due to

Other Conditions

Similarity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

D. P. Moore Langhlin

Address 400 N. Payson St.

Date signed 8/9/43

438367 ~~407027~~ BALTIMORE CITY HEALTH DEPARTMENT
 407027 CERTIFICATE OF DEATH 50 Registered No. 407027

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Helen Price

3 (b) If veteran, name war

N

3 (c) Social Security Account

No.

None

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

7-17-92

8. AGE: Years

51

Months

0

Days

22

If less than one day

hr.

min.

9. Birthplace

KANSAS

(Town, county, and state)

10. Usual Occupation

SECRETARY

11. Industry or business

FATHER
MOTHER

12. Name

John H Price

13. Birthplace

Ill.

14. Maiden Name

Ida Osborne

15. Birthplace

Ind.

16 (a) Informant

JOHNS HOPKINS HOSPITAL

(b) Address

17 (a)

Funeral

(b) Date thereof

8/9/43

(c) Cemetery or crematorium

Full view

(d) Location

Full view of river

18 (a) Funeral director

Full view of river

(b) Address

1217 St Paul St

19 (a)

(b) Registrar

Full view of river

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 209 W. Monument

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1943, at 3:10 A

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943 to Aug 7 1943 and that I last saw her alive on Aug 7 1943

Immediate cause of death Generalized carcinoma of the breast

Duration

Typ.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1942

Major findings of operation Malignant

tumor of breast

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. S. Cross Jr.

Address J. H. H.

Date signed 8-7-43

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

507028

47c 507028

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Street (b) County

(c) City or town

(If outside city or town limit, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles J. Hynson

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) Date rec'd by registrar

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 7 1943

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1942 to Aug 7 1942 and that I last saw him alive on Aug 7 1942.

Immediate cause of death

Post Operative Thoracic Hemorrhage

Due to

Due to

Other Conditions

Bronchogenic Squamous Cell Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

July 7, 1942

Major findings of operation

As above

of autopsy: Refused

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

8/12/43

G 07029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07029
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4103 E. Lombard St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Marva Gunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1939

8. AGE:

Years

Months

Days

If less than one day

33 1/292

hr.

min.

9. Birthplace

Tenn

(Town, county, and state)

10. Usual Occupation

Chief

11. Industry or business

FATHER

12. Name

J. C. Gunn

13. Birthplace

Champ Tenn

MOTHER

14. Maiden Name

Grace Young

15. Birthplace

Pikeville Tenn.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Aug 10/43

(Burial, cremation, or removal)

(c) Cemetery or place of interment

Forest Hill

Location

Chattanooga Tenn

18 (a) Funeral director

John C. Mitchell

(b) Address

1900 E. Lucas Pl.

19 (a)

Aug 8, 1943

(b) Date of death

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1943 at 3:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7, 1943, to Aug 7, 1943 and that I last saw him alive on Aug 7, 1943

Immediate cause of death

Cardiopulmonary failureDue to Concussion of HeadTetralogy of FallotDue to Acute - decompensationvomiting

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Helen Bowie

Address

Johns Hopkins Hosp.Signed 8/11/43

correct age is especially important

G 07030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07030

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland 1200 Valley St.
 (b) Street address
 (c) Hospital or institution: Home for the Aged
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Balto
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1200 Valley St
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Frank Ohlendorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Margaret Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 Aug 1857

8. AGE: Years Months Days If less than one day

86 11 15 hr. min.

9. Birthplace Baltimore City Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Ohlendorf

13. Birthplace Germany

14. Maiden Name Margaret Schibald

15. Birthplace U.S.A.

16 (a) Informant Sister of the Deceased

(b) Address 1200 Valley St Baltimore

17 (a) Burial (b) Date thereof Aug 9 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Weddfield

(b) Address 917 Drummond Ave

19 (a) 1943 (b) Huntington Hills, Md

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1943 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1943 to Aug 6 1943.

and that I last saw him alive on Aug 6 1943.

Immediate cause of death General

Toxemia

Chr Nephritis 7 days

Due to Foh myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide none

(b) Date of occurrence none at M

(c) Where did injury occur? none
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? none
(Specify type of place)

(e) Means of injury none

23. Signature E. H. Dwyer

Address 928 E. North Ave Date signed 8/7/43

Duration

7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

07032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07032

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

life

2. USUAL RESIDENCE OF DECEASED:

(a) State MA

(b) County Balto

(c) City or town

Halethorpe

(If outside city or town limits write RURAL and give town)

(d) Street No. 1319 Elm Rd.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Mary A. Baxter

3 (b) If veteran, name war

3 (d) Social Security Account

No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John J. Baxter

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

3/17/86

8. AGE:

Years

Months

Days

If less than one day

57

4

1921

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name

John J. Baxter

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Mary A. Nolker

15. Birthplace

Balto Md.

16 (a) Informant

J. J. E. Baxter. (son)

(b) Address

1319 Elm Rd Halethorpe

17 (a) BURIAL

(b) Date thereof

AUG 13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

HOLY CROSS

A.A.CO.

18 (a) Funeral director

Bernard E. Hark

(b) Address

121 E. W. ST

(c) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/8

1943, 10³⁰ a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1943 to 8/8 1943.

and that I last saw him alive on 8/8 1943.

Immediate cause of death

Mesenteric Thromboses

of localized Peritonitis

Due to Intestinal obstruction

Duration

24 hrs.

Due to Annular Carcinoma of Colon (descending)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8/3/43

Major findings of operation

Intest. obstr.

③ Annular Ca. Colon.

Peritonitis localized

of mesenteric thromboses

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward L. Krueger

Address Bon Secours Hosp

Date signed

F. D.

G 07033

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07033
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Apt #1*
 (b) Street address *3706 N. Charles St*
 (c) Hospital or institution *Buckingham Arms Apt.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *15 yrs*
 (e) Length of stay in Baltimore (yrs., mos., or days) *15 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto*
 (c) City or town *Balto*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3706 N. Charles St. Apt #1*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

John Samuel Reese

3 (b) If veteran, name war

3 (c) Social Security Account

217-098043

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Lily V. Reese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

Feb 11 1883

8. AGE:

Years	Months	Days	If less than one day
<i>60</i>	<i>5</i>	<i>27</i>	<i>hr. min.</i>

9. Birthplace

Sidney N.Y.

10. Usual Occupation

Fireman

11. Industry or business

Bull S. S. Co.

12. Name

Albert Reese

13. Birthplace

N.Y.

14. Maiden Name

Unknown

15. Birthplace

"

16 (a) Informant

Mrs. Lily Reese

16 (b) Address

*3706 N. Charles St*17 (a) *Burial**(Burial, cremation, or other)*

17 (b) Date thereof

8/11/43

17 (c) Cemetery or crematory

St. Carmel

17 (d) Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

18 (b) Address

217 St. Paul St

18 (c) Date rec'd by registrar

August 9 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 8 1943* at *4:45 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *July 1 1943* to *Aug 8 1943*, and that I last saw him alive on *Aug 7 1943*.

Immediate cause of death

*Pulmonary edema**Myocardial degeneration*Due to *Coronary disease*Due to *Arterio-sclerosis*Other Conditions *Left side vascular thrombosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature *A.T. Rice*Address *24 S. Broadway* Date signed *Aug 8 1943*

Duration

*1 day**1 yr +**1 yr +**1 yr +**1 yr +**1 yr +**1 yr +**6 weeks*

07034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07034
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1714 E. Monument St.

(c) Hospital or institution:

Sumner Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louise Von Hohenhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

W

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband

Richard W. Hohenhoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. Oct 12 1883

8. AGE:

Years

59

Months

9

Days

25

If less than one day

hr. min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

Harry Rochester

13. Birthplace

Unknown

14. Maiden Name

Emma S. Ruckl

15. Birthplace

Va.

16 (a) Informant

Elsa Von Hohenhoff

(b) Address

2418 N. Charles St.

17 (a)

Burial

(b) Date thereof

8/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Greenmount

Location

Balto Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

(b)

(Date rec'd by registrar)

William Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2418 N. Charles St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7, 1943 at 10:15 PM21. I certify that death occurred on the date above stated; that I attended deceased from June 14, 1943 to Aug 7, 1943, and that I last saw her alive on Aug 7, 1943Immediate cause of death Pneumonia

Duration

Due to Post-operative52 days

Due to

Other Conditions Gastric carcinomaGastric - enterostomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Gastric carcinomawith metastasis to other organs

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Henry J. Smith

M. D.

Address

Sumner HospitalDate signed 8-7-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56a Registered No. 07035

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Madison & Park
(c) Hospital or institution: Md. Se. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8/3/43 to 8/8/43 15 days
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Balt.
(c) City or town: Balt.
(d) Street No.: 3404 Hilltop Rd.
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Miss Margaret M. Kine

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: No

6 (b) Name of husband or wife: _____
6 (c) If alive, give age: _____ years

7. Birth date of deceased (mo., day, yr): April 24 - 1876

8. AGE: Years: 67 Months: 3 Days: 14 If less than one day: hr. min.

9. Birthplace: Balt. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: _____

12. Name: Patrick J. King

13. Birthplace: Balt. Md.

14. Maiden Name: Lelia Tootell

15. Birthplace: Balt. Md.

16 (a) Informant: Mrs. George Kirkness

16 (b) Address: 340 N. Hilton St.

17 (a) Burial (b) Date thereof: Aug-11-43

(c) Cemetery or crematory: Mt. Carmel

18 (a) Funeral director: Wm. Cook, Inc.

18 (b) Address: 217 28th Ave. S.E.

19. Date of death: AUG 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/8 1943 at 3:45 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from 8/3 1943 to 8/8 1943 and that I last saw her alive on 8/8 1943.

Immediate cause of death: Pulmonary edema and congested heart failure following surgical removal of large multi-lobular cystic left ovary

Due to: _____

Other Conditions: _____

(Include pregnancy within 3 months of death)

Date of operation: 8/2/43

Major findings of operation: Large multi-lobular cyst of left ovary

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: _____ at _____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury: _____

23. Signature: J. W. Harris Address: Md. Se. Hosp. Date signed: 8/10/43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

07036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07036
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or Business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Address

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b) (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941, to Aug 7 1942, and that I last saw him alive on Aug 6 1942.

Immediate cause of death

Pulmonary edema
Myocardial infarction
Due to coronary disease
arteriosclerosis

Due to

diabetes mellitus

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 07037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07037
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19

AUG 9 - 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943, to Aug 6 1943, and that I last saw him alive on Aug 6 1943

Immediate cause of death

myocarditis
Due toDue to Diabetes
Carbuncle on
Other Conditions neck

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07038

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *1213 Light St.*
- (c) Hospital or institution:
South Baltimore General Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2 mo.*
- (e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
- (c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *306 E. Fort Ave.*
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Michael Lee

3 (b) If veteran, name war

3 (c) Social Security Account
No. *212-07-9618*

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*

- 6 (b) Name of husband or wife *Veronica Adams*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 27, 1883*

8. AGE: Years *60* Months *1* Days *8* If less than one day
hr. min.

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation *Crane Operator*

11. Industry or business *Arundel S. & Co.*

12. Name *?*

13. Birthplace *?*

14. Maiden Name *?*

15. Birthplace *?*

- 16 (a) Informant *Family*

- (b) Address *306 E. Fort Ave.*

- 17 (a) *D.* (b) Date thereof *8-9-43*
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory *London Pk.*

- Location *Federick Rd*

- 18 (a) Funeral director *James L. McQuerry*

- (b) Address *136 E. Fort Ave.*

- 19 (a) *AUG 9 - 1943* *Huntington Hills, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 5, 1943, at 4:00 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *May 20, 1943, to Aug. 5, 1943*, and that I last saw him alive on *Aug. 5, 1943*.

Immediate cause of death *Engorgement*

Duration

Due to *Plumage*Due to *(none)*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur?
(City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

- (e) Means of injury

23. Signature *Paul H. Zukate* M. D.

Address *1213 Light St.* Date signed *5/1/44*

07039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 07039

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1943 to 8-7 1943 and that I last saw her alive on 8-7 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

07040

HEALTH DEPARTMENT—CITY OF BALTIMORE

07040

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: No. 110 S. Calhoun St., Ward 119a

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 3 mos. 4 ds. How long in U. S. If of foreign birth? yrs. 3 mos. 4 ds.

2. FULL NAME

Janet Blaire Fisher 19-3

U. S. Veteran

specify WAR

(a) Residence: No. 110 S. Calhoun St., Ward 119a

(Usual place of abode)

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. Color or Race <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Infant</u>
6a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day, year) <u>May 6-1943</u>		
7. AGE	Years <u>0</u>	Months <u>3</u>
	Days <u>0</u>	If LESS than 1 day, hrs. _____ or min. _____
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Child</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____	
	10. Date deceased last engaged at this occupation (month and year) _____	
11. Total time (years) spent in this occupation _____		
12. BIRTHPLACE (city or town) <u>Baltimore</u> (State or country) <u>MD</u>		
FATHER	13. NAME <u>Gilbert C Fisher</u>	
	14. BIRTHPLACE (city or town) <u>VA</u> (State or country) _____	
MOTHER	15. MAIDEN NAME <u>Ruth Krummel</u>	
	16. BIRTHPLACE (city or town) <u>Bald</u> (State or country) <u>MD</u>	
17. INFORMANT <u>Gilbert C Fisher Sr</u> (Address) <u>110 S Calhoun St</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>Meadowridge</u> Date <u>8/9/43</u>		
19. UNDERTAKER <u>Geo. L. Bayer Jr</u> (Address) <u>1012 N. Hollman</u>		
20. DATE OF DEATH <u>Aug 9-1943</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) <u>Aug 6 - 1943</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>Aug 5, 1943</u> to <u>Aug 6, 1943</u> I last saw him alive on <u>Aug 5, 1943</u> Death is said to have occurred on the date stated above, at <u>12:40 PM</u>
The principal cause of death and related causes of importance were as follows: <u>Infant death</u>
Other contributory causes of importance: <u>Heart trouble</u>
Was an operation performed? <u>No</u> Date of _____
For what disease or injury? _____
Name of operation _____
What test confirmed diagnosis? <u>None</u> Was there an autopsy? _____
23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? <u>None</u> Date of injury _____, 19____
Where did injury occur? <u>None</u> (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? <u>No</u> If so, specify _____
(Signed) <u>Gilbert C Fisher</u> M. D. (Address) <u>2502 Calhoun Ave</u>

07041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 07041

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1132 Mosher St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1132 Mosher St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. Joseph Burr

4. Sex M

5. Color or race C

6 (a) Single ☒ married ☒ widowed, or divorced.

212-01-4024

6 (b) Name of husband or wife Agnes Burr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1880

8. AGE: Years 62 Months 5 Days 15
If less than one day hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Billie Burr

13. Birthplace Md.

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Agnes Burr

(b) Address 1132 Mosher St.

17 (a) (b) Date thereof Aug 6-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore City

18 (a) Funeral director Geo. A. Telson

(b) Address 1303 Presstman St.

19 AUG 9 - 1943 (d) by Dr. Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1943 at M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic

cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Gustafson M.D.

Date signed August 8 1943

7042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67042

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Baltimore St.

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Sep 15/43

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3716 Yosemite Ave
(If rural give location)(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby. Mc Keaney

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

F

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/4/43

8. AGE: Years Months Days If less than one day

Sep 15/43

3-15 hrs

hr.

min.

9. Birthplace Bon Secours Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John M^c Keaney

13. Birthplace Philadelphia - Pa

14. Maiden Name Mary Brady

15. Birthplace Baltimore - Md.

16 (a) Informant Bon Secours Hosp.

(b) Address 2025 W. Baltimore St.

17 (a) Burial (b) Date thereof Aug 9-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Bon Secours

Location Old Frederick Rd.

18 (a) Funeral director John A. Morgan

(b) Address 2025 E. Baltimore St.

AUG 9 - 1943

(Witnessed by) Dr. William M. B.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-1943, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-1943, to 8-8-1943 and that I last saw her alive on 8-8-1943.

Immediate cause of death

Abortion 22 weeks.

Duration

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. J. Jones

Address M. J. Jones Date signed 8-8-43

G 07043 MJ-82747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07043
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(b) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(c) Street No. NO HOME

(If rural give location)

(d) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph Sturgeon

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Separated

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1883

8. AGE:

Years 60

Months 1

Days 17

If less than one day

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Agustif Sturgeon

13. Birthplace Maryland

14. Maiden Name Mary Gogan

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8-9-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory location E North Ave Exp

18 (a) Funeral director Les S. Gough

(b) Address 701-03 N. Pat's Park Ave

19 (a) (b)

(Date rec'd by registrar)

AUG 9 - 1943

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7/1943 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended
deceased from 7/20 8:15 to 8/7 1943.

and that I last saw him alive on 8/7 1943.

Immediate cause of death

Branchiopneumonia, St.
upper lobe & sec.
chronic atelectasis

Duration

2 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. J. Sengman

Address B C H

Date signed 8/7

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07044

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1 N Hiltz St*
(If rural give location)(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME

ROBERT

JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *NOV. 7-1896*8. AGE: Years Months Days If less than one day
46 8 28 hr. min.

9. Birthplace

CLIFTON FORGE, VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name *Robert Riley Johnson*13. Birthplace *Nelson Co., VA.*14. Maiden Name *MARGARET CLINE*15. Birthplace *AVGUSTA Co., VA.*16 (a) Informant *THORNION JOHNSON*(b) Address *CLIFTON FORGE, VA*17 (a) *Cremation* (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)(c) Cemetery or crematory *Fondor Road 8-9-43*Location *Frederick Rd.*18 (a) Funeral director *Leo & Cook*(b) Address *1111 N. Hiltz St*(Date rec'd by registrar) *AUG 9-1943* Registrar *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 7* 19 *43* at *9 45* M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☒ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

*Undetermined -
decomposed
Chronic alcoholism*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature *W. W. Allen, M.D.*Date signed *8-7-43*

SM
G 07045
82530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07045
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1405 Argyle Ave.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

John Thomas

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Everie Thomas

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1909

8. AGE: Years

34

Months

6

Days

22 21

If less than one day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Mitchell Thomas

13. Birthplace Md.

MOTHER

14. Maiden Name Lula Turner

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof Aug. 11-1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director D. Brooks

(b) Address 1463 N. Carey St

19 (a) (b)

(Date rec'd by registrar)

Registrar

VS 114
AUG 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1943, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1943 to 8/7 1943, and that I last saw him live on 8/7 1943.

Immediate cause of death

Pulmonary T.B.C.

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

BCH

Date signed

E. L. Serpinin
8/8/43

G 07046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07046

Registered No.

83a

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Partner

12. Name

Robert A. M. Oler

13. Birthplace

Baltimore, Md.

14. Maiden Name

Mary Brashears

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mrs. Gertrude V. Oler

(b) Address

102 Locust Drive, Larchmont

17 (a)

Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore, Md.

18 (a) Funeral director

E. W. Hamoran

(b) Address

4510 Liberty Heights Ave.

19 (a)

AUG 9 - 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/7

1943, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1943, to 8/7 1943.

and that I last saw him alive on 8/6 1943

Immediate cause of death

Cerebro-vascular accident

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Md. Gen. Hosp.

Date signed 8/7/43

Duration

7/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07047
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **139 N. Ellwood Ave.**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **139 N. Ellwood Ave.**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Christina Marquard

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced **Married**6 (b) Name of husband or wife **Chas. P. Marquard**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 13th. 1865**

8. AGE:

77

Years

Months

8

Days

20 24

If less than one day

hr.

min.

9. Birthplace **Baltimore Md.**

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name **John C. Heller**13. Birthplace **Germany**14. Maiden Name **Rebecca Hepps**15. Birthplace **Germany**16 (a) Informant **Mr. Chas. P. Marquard**(b) Address **139 N. Ellwood Ave.**17 (a) **Burial** (b) Date thereof **Aug. 10/43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **St. Matthews Cem.**

Location

Baltimore Md.

18 (a) Funeral director

Philip Murray
2024 Orleans St.

(b) Address

19 (a) **AUG 9 - 1943**

(Date rec'd by registrar)

Antoinette Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 7th/43** 19 at M21. I certify that death occurred on the date above stated; that I attended
deceased from **Aug 3, 1943** to **Aug 7, 1943**
and that I last saw him alive on **8-7-1943**.

Immediate cause of death

Chronic myocarditis

Duration

1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **C. W. Peake**Address **4508 Harford Road** Date signed **8-9-43**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07048

439081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07048
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

503 N. Washington

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ellsworth Kober

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-2-09

8. AGE:

Years

Months

Days

If less than one day

34

7

5

hr.

min.

9. Birthplace

D.C.

(Town, county, and state)

10. Usual Occupation

Printer (Self)

11. Industry or business

FATHER
MOTHER

12. Name

Clarence Kober

13. Birthplace

D.C.

14. Maiden Name

Emma ?

15. Birthplace

D.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof Aug. 10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Cem.

Location

Balto. Md.

18 (a) Funeral director

Philip Murray Sons

(b) Address

2024 Orleans St.

19 (a)

AUG 9 - 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 7, 1943, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4, 1943, Aug. 7, 1943, and that I last saw him alive on Aug. 7, 1943.

Immediate cause of death

Cardiac failure

Due to

Rheumatic heart disease & aortic &

Due to

mitral stenosis & insufficiency, aortic

Other Conditions

fibrillation & pleural effusion

(Include pregnancy within months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Roxie Day

23. Signature

John Hopkins Hosp.

Address

Date signed 9/7/43.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33a

G 07049

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Woman's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1908 Chelsea Rd

(If rural give location)

(e) Citizen of foreign country?

?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Josephine Salvato

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 30, 1893

8. AGE:

Years

Months

Days

If less than one day

58

76

18

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Gasullo

13. Birthplace

Italy

14. Maiden Name

Anna Labasse

15. Birthplace

Italy

16 (a) Informant

Mark L. Gasullo

(b) Address

1194 Green Ave. Brooklyn NY

17 (a) R MOVAL

(b) Date thereof

8/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Brooklyn N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa Aves Baltimore Md

19 (a)

AUG 9 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/8/43

19

at

9:15 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

7-29

1943 to

8-8

1943.

and that I last saw h. alive on

8/5

19.43

Immediate cause of death

Cardio-vascular failure

Due to

Hypertension

Due to

Pneumia

Other Conditions

(none)

(Include pregnancy within 3 months of death)

Date of operation

none

Major findings of operations

of autopsy: Cardiac pneumonia (autopsy)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

1943

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Franklin E. Lasker

Address

Woman's Hospital

Date signed

8/8/43

07050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07050

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution:

Union Memorial Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3709 Elkader Road
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Hall Leonard

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widower W

6 (b) Name of husband or wife Mrs. Robert Hall Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1867

8. AGE: Years Months Days If less than one day

76

3

18

hr.

min.

9. Birthplace

Easton Maryland
(Town, county, and state)

10. Usual Occupation Retired Postal Worker

11. Industry or business Post Office

12. Name Edwin F. Leonard

13. Birthplace Easton Maryland

14. Maiden Name Anna M. Larrimore

15. Birthplace Easton Maryland

16 (a) Informant Mr. Russell C. Leonard

(b) Address 3709 Elkader Road

17 (a) Burial (b) Date thereof 8/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loddon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC

(b) Address North & Pa. Aves.

19 (a) AUG 9 - 1943
(Date for registration)

Huntington Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1943 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943, to Aug. 7 1943, and that I last saw him alive on Aug. 7 1943.

Immediate cause of death Coriary - Respiratory failure

Duration

Due to Cerebral hemorrhage

?

Due to Arterio-sclerosis

Other Conditions Lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Muzatova, M.D.
Address 332 E. University Ave. signed 8/7/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07051
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.Y. (b) County

(c) City or town Elmira

(If outside city or town limits, write RURAL and give town)

(d) Street No. 101 Canton St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Gertrude Fetter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife William Fetter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1865

8. AGE: Years Months Days

77

9

14

If less than one day

hr.

min.

9. Birthplace Caroline Co. Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

12. Name James Adams

13. Birthplace Md.

14. Maiden Name Elizabeth Nichols

15. Birthplace Md.

16 (a) Informant Mr. Charles Hartman

(b) Address 1606 E. 32nd St. Balto.

17 (a) Burial (b) Date thereof Aug. 9, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons,

(b) Address North & Pa. Aves.

19 (a) AUG 9 - 1943

(Date of registration)

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1943, 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1943 to 8-5-1943 and that I last saw her alive on 8-5-1943

Immediate cause of death

Anesthetic death
Santocaine-glucose anesthesia

Due to

Due to

Other Conditions Fracture of neck

of Rt. femur

(Include pregnancy within 3 months of death)

Date of operation Anesthesia 8-5-43

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

External Cause Accident 9/6

(a) Accident, suicide, or homicide

(b) Date of occurrence 7-31-43 6:42 P.M.

(c) Where did injury occur? Baltimore, Maryland

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home

(Specify type of place)

(e) Means of injury Fall down steps

23. Signature Emerson M. Cheek, M.D.

Address WTBG Date signed 8-5-43

Approved: Robert Lee Graham, M.D. Authorized by Dr. Graham, Med. Examiner

G 07052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07052

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Genl Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2.0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

131

Welcome Alley

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles

Callfield

3 (b) If veteran, name war

no

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11.9.8

8. AGE: Years

45

Months

Days

If less than one day

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mary Miles

(b) Address

131 Welcome Alley

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

(month) (year)

Aug 9-43

(c) Cemetery or crematory

Mt Calvary

Location

A.A. Co. Mt

18 (a) Funeral director

James A. Adams

(b) Address

142 W. 11th St

19 (a)

(b) Date

Aug 9-1943

(c) Signature of Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 5 1943 at 8 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pulmonary edema

Due to

Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert E. Graham M.D.

Date signed

August 6 1943

G 07053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07053

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1410 E. Monument St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2

3 (a) FULL NAME

Carrie Avery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female Col

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

J. W. Avery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 20, 1864

8. AGE:

Years

Months

Days

If less than one day

78

11

15

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

James Deaver

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Emma Oliver

15. Birthplace

Baltimore, Md.

16 (a) Informant

Dr. William Avery

(b) Address

1410 E. Monument St.

17 (a)

Burial

(b) Date thereof

8/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Carey Cem.

Location

A. A. County, Md.

18 (a) Funeral director

Joseph B. Becker, Jr.

(b) Address

1506 N. Central Ave.

19 (a)

AUG 9 - 1943

(b)

Thurston Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1410 E. Monument St.

(If rural give location)

(e) If foreign born, how long in U. S. A?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 5, 1943, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1943, to Aug. 4, 1943, and that I last saw him alive on Aug. 5, 1943.

Immediate cause of death

Due to

Apoplexy

Due to

Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. Edgar Fisher

Address

1410 E. Monument St.

Date signed

8-6-43

07054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07054
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland *found in basket*
(b) Street address *apt of Hull-H*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) *7*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town *Newport, England*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *55 East Hudson Ave*
(If rural give location)
(e) Citizen of foreign country? *Yes* (Yes or No)
If yes, name country *England*

3 (a) FULL NAME *JOSEPH M C CARTHY*

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *m* 5. Color or race *w* 6 (a) Single, married, widowed, or divorced *Single*

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 7th 1910*

8. AGE: Years Months Days If less than one day
32 1 22 hr. min.

9. Birthplace *Ireland*
(Town, county, and state)

10. Usual Occupation *Seaman*

11. Industry or business *U.S. Fort Hudson Hope*

12. Name *Unknown Mc Carthy*

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *British Consul*
(b) Address *Marquette Trust Co.*

17 (a) *Funeral* (b) Date thereof *8/9/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Lorraine*
Location *Baltimore Md.*

18 (a) Funeral director *Brookline*
(b) Address *1217 N. Paul St. Balto.*

19 (a) (b)
(Date rec'd by registrar) Registrar

20. DATE OF DEATH *Aug 6 1943 at 4:30 PM*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH *drowning*

Due to

Other Conditions *no*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury *7-28-43* *24/1* M.
(b) Where did injury occur? *hull*
(c) Did injury occur at home, on farm, industrial place, in public place? *inside* While at work?
(d) Means of injury *drowning*

23. Signature *J. J. Wollmuth M.D.*
Date signed *8-7-43* Medical Examiner.

1943-1943

G 07055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07055

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 9 - 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 9 8 1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1943 to Aug 8 1943, and that I last saw him live on Aug 8 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07056

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2101 W. Gold Spring Lane*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *27*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Benjamin F. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color of race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Fannie Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 23/1852

8. AGE:

Years

Months

Days

If less than one day

*90**8**16**15*

hrs.

min.

9. Birthplace

Howard Lea Md

(Town, county, and state)

10. Usual Occupation

Retired farmer

11. Industry or business

12. Name

Elias S Lee

13. Birthplace

Maryland

14. Maiden Name

Sarah Sumner

15. Birthplace

Maryland

16 (a) Informant

John Fletcher Lee

(b) Address

Westminster Md.

17 (a)

Burial

(b) Date thereof

8-10-43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

*London Park**Baltimore Md*

18 (a) Funeral director

Manie Cook, Super

(b) Address

1600 W. North Ave

19 (a)

(b)

AUG 9 - 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2101 W. Gold Spring Lane

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Aug. 8 1943, at 9:45 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *June 25 1943* to *Aug. 5 1943*, and that I last saw him alive on *Aug. 6 1943*.

Immediate cause of death

chronic myocarditis

Duration

Due to

Due to

Other Conditions

remedy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

*Dr. W. R. Putterman*Address *2324 Reisterstown Rd* Date signed *8/8/43*

M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07057

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1605 Lamont Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
(c) City or town - Baltimore
(If outside city or town limits, write RURAL and give town)
1605 Lamont Avenue
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME

Hollie M. Chilcote

3 (b) If veteran, name war

None

3 (c) Social Security Account

None

4. Sex
Female5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frederick C. Chilcote

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) March 30, 1909

8. AGE: Years 34 Months 4 Days 6 If less than one day
min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

12. Name Thomas J. Mc Cune

13. Birthplace Pennsylvania

14. Maiden Name Anna Schultz

15. Birthplace Pennsylvania

16 (a) Informant Frederick C. Chilcote (Husband)

(b) Address 1605 Lamont Avenue

17 (a) Burial (b) Date thereof 8/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Eastern
Location

18 (a) Funeral director George J. ...
(b) Address 1748 Harford Avenue

19 (a) AUG 9 - 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6th 1943, 6/45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 19...
and that I last saw him alive on 19...

Immediate cause of death

terminal pneumonia

Duration

2 days

Due to carcinoma of cervix

5-6 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Samuel L. ...

Address 714 E. ... Date signed 8/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07058
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) AUG 9 - 1943

(b) Date rec'd by

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw h

e alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

07059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07059

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1612 Hazel St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ANTONI

SZAFRANEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 1872

8. AGE:

Years 70

Months 11

Days 5

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Retired - Pumper

11. Industry or business

Darrin Chemical Co.

FATHER

12. Name

Szafranek

13. Birthplace

Poland

14. Maiden Name

—

15. Birthplace

Poland

16 (a) Informant

Josephine Ptanowski

(b) Address

1612 Hazel Street

17 (a)

Burial

(b) Date thereof

8-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Cross Cem.

Location

Crown Highway

18 (a) Funeral director

Wm. S. Fialkowski

(b) Address

2007 Eastern Ave

19

AUG 9 - 1943

Huntington Williams

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1612 Hazel St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 6, 1943 at 11:50 M

21. I certify that I took charge of the remains described above, held an

Autopsy, inspection or inquiry

thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

H. Z. Wallenweber M.D.

Date signed

8-9-43

Medical Examiner

07060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07060
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3303 Clyde St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3303 Clyde St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Martin C. Schattner

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-10-2582

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife M. Katherine Sauter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1879

8. AGE: Years Months Days If less than one day

6381312

hr.

min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Trucker11. Industry or business PENN. R.R.12. Name Not known13. Birthplace Germany14. Maiden Name Not known15. Birthplace Germany16 (a) Informant M. Katherine Schattner(b) Address 3303 Clyde St.17 (a) Burial (b) Date thereof 8/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak LawnLocation Eastern Ave.18 (a) Funeral director Clarence F. Hoffmann(b) Address 1639 N. Broadway.AUG 9 - 1943

(Date rec'd by registrar)

(c) Thurston Williams

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1943 at 1:00 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28, 1943 to Aug 5, 1943and that I last saw him alive on Aug 4, 1943

Immediate cause of death

Acute Coronary ThrombosisDue to Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 5010 Greenleaf RdDate signed 8/7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

SM

061

82729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07061

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

3 (a) FULL NAME

Addie Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1912

8. AGE: Years Months Days If less than one day

31 yrs - 30 29 hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
MOTHER

12. Name John Austin

13. Birthplace Va.

14. Maiden Name Sallie John

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof Aug 10, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Hillwyn
Location Virginia

18 (a) Funeral director M. A. Williams

(b) Address 322 N. Schenck St.

19 (a) (b)
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 906 N. Fremont Ave.

(e) Citizen of foreign country? No (If rural give location) (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1943 at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1943 to 8/7 1943 and that I last saw her alive on 8/7 1943.

Immediate cause of death

Peritonitis & pneumonia
Due to infected pelvic thrombophlebitis & blood lg. abscess
Due to Post-partum endometritis

Other Conditions

Sec. anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: In post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, or public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sugman

Address A C H

Date signed 8/11/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439209

G 07062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07062
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHN HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **15**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1847 Preestman**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Martha Dickey

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female Black

5. Color or race

6 (a) Single, married, widowed, or divorced

Sep-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **3-28-16**8. AGE: Years Months Days If less than one day
57 4 10 hr. min.9. Birthplace **Miss**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Jeane Ramsey**13. Birthplace **?**14. Maiden Name **Alice Jones**15. Birthplace **Miss**16 (a) Informant **Records**(b) Address **JOHN HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **8-10-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Mt Auburn**Location **Paeto, Md.**18 (a) Funeral director **William A. Jackson**(b) Address **916 Penna, Ave**19 (a) **10-13-43** (b) **William A. Jackson**
(Date of registration) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 8 1943 at 1:30 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 6 1943 to Aug 8 1943** and that I last saw him alive on **Aug 8 1943**.Immediate cause of death **hypertensive pulmonary infarction**Due to **hypertensive-arterio-sclerotic C-V. disease**

Due to

Other Conditions **old rheumatic mitral valve**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy **RLC infarction; pulmonary**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **John R. Birmingham**
J. H. H. M. D.Address **J. H. H.** Date signed **8-9**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07063
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1943 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from July 1, 1942 to Aug 6, 1943.
and that I last saw him alive on Aug 6, 1943

Immediate cause of death

Duration

Acute Cardiac Dilatation

1 hr.

Due to

Cardiac Hypertension

not known

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address

1076 West St.

Date signed

M. D.

Aug 6, 1943

G 07064

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07064

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2221 Essex Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4

(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2221 Essex Street
(If rural give location)(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME

Karolina Kulisiwicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1887

8. AGE: Years 55 Months 8 Days 6 hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

12. Name

Joseph Praglawski

13. Birthplace

Poland

14. Maiden Name

Agnes Filipch

15. Birthplace

Poland

16 (a) Informant Josephine Kulisiwicz

(b) Address 2221 Essex Street A. Kulisiwicz

17 (a) Burial (b) Date thereof 8/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Welby

(b) Address 401 S. Chester Street

19 (a) AUG 9 - 1943 (b)

(c) Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1943, at 11:30 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Aug. 6, 1943, to Aug. 6, 1943, and that I last saw her alive on Aug. 6, 1943.

Immediate cause of death

Cerebral apoplexy acute

Due to Cerebral arteriosclerosis

and Ch. Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07065

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.(b) County Baltimore

(c) City or town:

(If outside city or town limits, write RURAL and give town)

(d) Street No. 202 Woodward Drive

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Molly Berezd.

3 (b) If veteran, name was

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female WhiteMarried

6 (b) Name of husband or wife

Stanislaw Bereza

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

57

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

House Work

11. Industry or business

at home

FATHER

12. Name

Joseph Stasewski

13. Birthplace

Poland

MOTHER

14. Maiden Name

M. Jankowski

15. Birthplace

Poland

16 (a) Informant

Stanislaw Bereza

(b) Address

202 Woodward Drive17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof

Aug. 10/43

(c) Cemetery or crematory

Holy Rood

Location

Baltimore

18 (a) Funeral director

W. Ozarkowski

(b) Address

1930 Eastern Ave.19 (a) Aug 10 1943(b) WashingtonRegistrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 1943 at 8:10 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1943 to 8-6-1943, and that I last saw her alive on 8-6-1943.

Immediate cause of death

Liver Shock.Due to Chronic Rholecystitis.

Due to

Other Conditions Hypertension.

(Include pregnancy within 3 months of death)

Date of operation

8/3/43

Major findings of operation:

Edema ofGall Bladder.

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William J. Jankowski

Address

St. Joseph's

Date signed

8/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07066

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematorium

18 (a) Funeral director

(b) Address

19 (a) Signature

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw heart alive on

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G 07067

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland *Madison & Lomb*
 (b) Street address *Madison & Lomb*
 (c) Hospital or institution *Maryland Gen. Hosp.*
8/5/43 - 8/8/43
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *15*
 (e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD.* (b) County *Baltimore*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3038 W. Hart Ave*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

William A. Manger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Florence Hildt Manger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 19 1874

8. AGE:

69

Years

20

Months

19

Days

*hr.**min.*

9. Birthplace

Baltimore Md.

10. Usual Occupation

Gen. Contractor

11. Industry or business

Cemetery

12. Name

Martin Manger

13. Birthplace

Germany

14. Maiden Name

Margaret Delphinus

15. Birthplace

Balt. Md.

16 (a) Informant

Flora May Barton

16 (b) Address

2935 Clifton Ave.

17 (a)

Burial

17 (b) Date thereof

Aug 10/43

17 (c) Cemetery or crematory

Druid Ridge

17 (d) Location

Pikesville

18 (a) Funeral director

John O. Mitchell

18 (b) Address

1900 Eutaw Place

19 (a)

Registrar

19 (b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/8/43 19 *at 5 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *8/5/43* 19 *to 8/8/43*last saw him alive on *8/8* 19 *43*

Immediate cause of death

Arterial sclerotic heart disease with myocardial degeneration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

F. J. McKinnis

Address

*Madison & Lomb*Date signed *8/8/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is important. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

Huntington Williams, M.D.

G 07068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07068

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Balto.

(c) City or town

Fullerton

(d) Street No.

Patty Hill Ave

(e) Citizen of foreign country?

(If rural give location)

(f) If rural give location

(g) If yes, name country

(Yes or No)

3 (a) FULL NAME

Mr. Leon Miller

3 (b) If veteran, name war

3 (c) Social Security Account

No.

Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced.

M.

6 (b) Name of husband or wife

Blanche

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

12-24-10

8. AGE:

Years

Months

Days

If less than one day

32

2

5

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

First Assembly

11. Industry or business

Blond Martin

12. Name

John W. Miller

13. Birthplace

Va.

14. Maiden Name

Annie Ayres

15. Birthplace

Va.

16 (a) Informant

Blanche Miller

(b) Address

Fullerton Md.

17 (a)

Removal

(b) Date thereof

Aug 8-43

(c) Cemetery or crematory

Broad Oak Cem.

Location

Natural Bridge Va.

18 (a) Funeral director

William Williams

(b) Address

1312 St. Paul St.

(c) Date rec'd by registrar

August 1943

(d) Registrar

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1943 at 6:50 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug. 5 1943 to Aug. 9 1943.

and that I last saw him alive on Aug. 9 1943.

Immediate cause of death

Acute Encephalitis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Lusting, M.D.

Address

St. Joseph Hosp.

Date signed 8-9-43

07069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07069

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Hospital for the Women of Maryland(d) Length of stay in hospital or inst. (yrs., mos., or days) *23*(e) Length of stay in Baltimore (yrs., mos., or days) *23*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*(c) City or town *Rosehilltown*
(If outside city or town limits, write RURAL and give town)(d) Street No. *None*
(If rural give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country3 (a) FULL NAME *Hannah Bailey Martin*

3 (b) If veteran, name war

3 (c) Social Security Account
No. *—*

4. Sex

Female

5. Color or race

*White*6 (a) Single, married, widowed, or divorced. *Married*6 (b) Name of husband or wife *William E. Martin*6 (c) If alive, give age *62* years7. Birth date of deceased (mo., day, yr.) *Feb 6 1884*8. AGE: Years *59* Months *6* Days *3* If less than one day
hr. min.9. Birthplace *Talbot Co. Md.*
(Town, county, and state)10. Usual Occupation *Housewife*

11. Industry or business

12. Name *John H. Bailey*13. Birthplace *Talbot Co. Md.*14. Maiden Name *Clara H. Tufford*15. Birthplace *Madison City, N. Y.*16 (a) Informant *Husband*(b) Address *None*17 (a) *Burial* (b) Date thereof *Aug 12, 1948*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Druid Ridge Cem*
Location *Pikeville, Md.*18 (a) Funeral director *C. H. Herry & Son*(b) Address *Pikeville, Md.*19 (a) *AUG 10 1948*

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 9 1948* *5:40 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *July 27 1948* to *Aug 9 1948*, and that I last saw him alive on *Aug 9 1948*.Immediate cause of death *Pulmonary*
edema due to cardio-
respiratory failure
Due to *Carcinoma of ovary,*
right with generalized
Ducto *metastasis*

Duration

*2 days**3 mos.*

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation *July 28 1948*
Major findings of operation *metastasis from carcinoma of*
ovary, right
of autopsy: *none*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature *William E. Gilmore* M. D.Address *Baltimore, Md.* Date signed *Aug 9 1948*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 07070
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

AUG 10 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1943, to Aug 6 1943, and that I last saw him alive on Aug 6 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Duration

3 wks.

2 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07071

MJ-81037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07071

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos., 19 days 3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 E. Pratt St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Nettie Miller

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

Separated

6 (b) Name of husband or wife Augustus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1879

8. AGE:

Years

Months

Days

If less than one day

64

0

17

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

On Relief

11. Industry or business

12. Name John Lynch

13. Birthplace Pa

14. Maiden Name Emma Pheobus

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) *Funeral* (b) Date thereof 8/11/43
(Burial, cremation, or removal) (month) (day) (year)

18 (c) Cemetery or crematory *Wheaton*

Location

18 (a) Funeral director *William J. Jones*

(b) Address

AUG 10 1943

(Date rec'd by registrar)

(b) *Huntington Williams, M.D.*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1943, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1943, to 8-8 1943.

and that I last saw him alive on 8-8 1943.

Immediate cause of death

Carcinoma of nasopharynx 14 ms
Due to *with metastases*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Donald B. Webb*

Address *Balti City Hosp* Date signed *8-9-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

7072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

7072

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1423 N. Wolfe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1423 - N Wolfe St

(e) Citizen of foreign country

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

Bernard A. Beran

3 (b) If veteran, name war

N

3 (c) Social Security Account

No.

NMF

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frances Beran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

About 1904

8. AGE:

Years

Months

Days

If less than one day

39

2

2

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

U.S. Coast Guard

12. Name

(Hakow) Beran

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant

Lloyd Edwards

(b) Address

2023 Cecil Ave

17 (a)

(Burial, cremation, or other)

Burial

(b) Date thereof

8/11/43

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md.

18 (a) Funeral director

William Oak Inc

(b) Address

1217 St. Paul St

AUG 10 1943

VB 128

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 9 - 1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943 to Aug 9 1943, and that I last saw him alive on 8/6/43.

Immediate cause of death Tuberculosis meningitis?

Duration

Due to

Miliary Tuberculosis

Due to

Pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy:

None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Alexander E. Brubaker

Address

119 N. Milton Ave

Date signed 8/19

67073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07073
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 816 W. 32nd St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 816 W. 32nd St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas E. Hudgins

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced

Widowed

6 (b) Name of husband or wife

Katie Hudgins

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Dec 19 - 1859

8. AGE:

Years

Months

Days

If less than one day

83

7

20

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Printer

FATHER

12. Name

Thomas Roe Hudgins

13. Birthplace

Md.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mrs Carolyn Mergon

(b) Address

816 W. 32nd St

17 (a)

Burial

(b) Date thereof

8/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Extended

18 (a) Funeral director

William Cook Inc

(b) Address

1001 St. Paul St

19 (a)

AUG 10 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 9

1943, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 to Aug 9 1943, and that I last saw him alive on Aug 8 1943.

Immediate cause of death

Carcinoma descending colon

Due to

Due to

Other Conditions

none except generalized atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Mons B. Schreiber

Address

J. S. Fulton Ave

Date signed Aug - 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every word on this certificate is a legal document. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07074

JL - B2955

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07074

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1524 John St

(e) Citizen of foreign country? (If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

Sue Girault

3 (b) If veteran, name war

N

3 (c) Social Security Account

No. N/A

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 21, 1880

8. AGE:

Years

Months

Days

If less than one day

63

6

18

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name Adolphis Meluin

13. Birthplace Md.

MOTHER

14. Maiden Name Belle Walton

15. Birthplace Md

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/11/1943

(Burial, cremation, or removal) (month), (day), (year)

(c) Cemetery or crematory London Park

Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

AUG 10 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1943, at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1943, to 8-8 1943,

and that I last saw her alive on 8-8 1943.

Immediate cause of death

Carcinoma of Breast
Due to with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald B. Helt

Address Balto City Hosp

Date signed 8-9-43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 07075
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.00

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1123 S. Pace St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Harry C. Claridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1878

8. AGE:

Years

Months

Days

If less than one day

64

8

13

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

Laborer

FATHER
MOTHER

12. Name

(Unknown) Claridge

13. Birthplace

Maryland

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Ella Claridge

(b) Address

1123 S. Pace Street

17 (a)

Burial (Burial, cremation, or removal)

Burial

(b) Date thereof

(month) (day) (year)

8/10/43

(c) Cemetery or crematory

Western

Location

Balto., Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. Paul St.

19 AUG 10 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1943 at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

arteriosclerosis

cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert Lee Graham

M.D.

Date signed

August 8 1943

G 07076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07076

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1831 E. Federal St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES RIESS, SR.

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Elizabeth Mary

Pessagno

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1885

8. AGE: Years

58

Months

7

Days

If less than one day

hr.

min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business Own business

12. Name Jacob Riess

13. Birthplace Germany

14. Maiden Name Anna ?

15. Birthplace Germany

16 (a) Informant Mr. Chas. J. Riess

(b) Address 4376 Shamrock Ave.

17 (a) Burial (b) Date thereof 8/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1849 E. North Ave.

19 (a) AUG 10 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1943 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 1943 to Aug 7 1943 and that I last saw him alive on Aug 7 1943

Immediate cause of death

Coronary failure

Due to

Pneumonia, generalized

Due to

Atherosclerosis, left lower lobe

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 4 1943

Major findings of operation

Admission of pyelitis

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. H. Sander

Address 1849 E. North Ave.

Date signed Aug 7 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07077
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 623 N. Robinson St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Robinson St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CATHERINE GAIL

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Gail
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1866

8. AGE: Years 77 Months 1 Days 15 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

12. Name Conrad Ritz

13. Birthplace Germany

14. Maiden Name Margaret Ritter

15. Birthplace Germany

16 (a) Informant Mrs. Margaret Smith

(b) Address 623 N. Robinson St.

17 (a) Burial (b) Date thereof 8/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Willard Funeral Home

(b) Address 2008 S. Orleans St.

19 AUG 10 1943 (b) Huntington Williams
Register

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 7 1943, at 1PM M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 4 1943, to AUG. 7 1943, and that I last saw her alive on AUG. 7 1943.

Immediate cause of death
Chronic myocarditis.

Due to

Due to

Other Conditions Acute gastroenteritis 4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. D. Smith
Address 701 N. Kenwood Ave. Date signed 8/7/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07078
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive & 31st St.
- (c) Hospital or institution:
U. S. Marine Hospital
Was admitted 8/9/43 at 1:15 A.M.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 8 min.
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
- (c) City or town 640 Wyeth Street, Baltimore, Md
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 640 Wyeth St., Baltimore, Md.
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN W. MITCHELL

3 (b) If veteran, name war
World's War3 (c) Social Security Account
No. 4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Marie Mitchell6 (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr) Aug. 8, 18978. AGE: Years Months Days If less than one day
46 0 1 hr. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Chauffeur11. Industry or business -12. Name John W. Mitchell13. Birthplace Baltimore, Md.14. Maiden Name Minnie Mitchell15. Birthplace Baltimore, Md.16 (a) Informant Records, U. S. Marine Hospital(b) Address Baltimore, Md.17 (a) Burial (b) Date thereof 8/12/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore National
Location Frederick Ave18 (a) Funeral director John J. Leonard & Son(b) Address 901 Hollins St.19 (a) (b)

Registrar

AUG 10 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 9, 1943 at 1:23 M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 9, 1943 to Aug. 9, 1943,
and that I last saw him alive on Aug. 9, 1943.Immediate cause of death Cardiac in-
sufficiencyDuration
Unk.Due to Arteriosclerotic heart
diseaseDue to Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Major findings of operations of autopsy: None

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No(b) Date of occurrence at M(c) Where did injury occur? (City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?(e) Means of injury 88923. Signature 889Address Baltimore, Md.Date signed 8/9/43

Va-13538

L. E. INES, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

G 07079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07079

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution:

Monument & Rutland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2221 E Baltimore St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Max Zallis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Married6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE: Years

62

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business Manf Waring Apparel12. Name Menasha Zallis13. Birthplace Russia14. Maiden Name Libba ?15. Birthplace Russia16 (a) Informant Gertrude Zallis(b) Address 2221 E Baltimore St17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof August 10,

(month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale CemLocation Hamilton Ave18 (a) Funeral director Sol Levinson & Bros(b) Address 1124 1126 W North Ave

19 (a) (b)

(Date rec'd by registrar)

AUG 10 1943
RegistrarHuntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9, 1943 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug 4, 1943 to Aug 9, 1943and that I last saw him alive on Aug 9, 1943Immediate cause of death Pulmonary Edema

Duration

Due to Cardiac Failure43daysDue to arteriosclerotic heartDiseaseOther Conditions Double Barrel BlotteryResection of Colon

(Include pregnancy within 3 months of death)

Date of operation 6-1-43, 7-29-43Major findings of operation: Carcinomaof sigmoid

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at 1943 M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Henry M. M. M.Address Sinai Hosp Date signed 8-9-43

G 07080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07080
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 842 W Lombard St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 842 W Lombard St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNIE K LIMAS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1979

8. AGE: Years

64

Months

Days

If less than one day

hr.

min.

9. Birthplace

Lith.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

John Popkewitz

13. Birthplace

Lith

14. Maiden Name

?

15. Birthplace

Lith

16 (a) Informant Joseph K Limas

(b) Address 842 W Lombard St.

17 (a) Burial (b) Date thereof Aug 11 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Blair Rd

18 (a) Funeral director Joseph H. Lawkenty

(b) Address 602 E. Lexington Blvd

19 (a) AUG 10 1943 Huntington Mill, Pa.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1943 at 9:20 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 6/9 1943 to 8/8 1943
and that I last saw him alive on 8/8 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

8/7/43

Due to Right Hemiplegia

6/9/43

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph H. Lawkenty

Address 679 W. Lexington Blvd signed 8/9/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important

G 07081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G 07081

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 305 E CROSS ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 305 E Cross St.
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

MARY A DETERS

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
FEM5. Color or race
WHITE6 (a) Single, married, widowed, or
divorced. WIDOW

6 (b) Name of husband or wife J. HENRY DETER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1 1864

8. AGE: Years 79 Months 7 Days 17 hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business

12. Name ABRAHAM BUSCH

13. Birthplace BALTO MD

14. Maiden Name ALICE RIGGAN

15. Birthplace BALTO MD

16 (a) Informant MISS ALICE DETERS

(b) Address 305 E CROSS ST.

17 (a) BURIAL (b) Date thereof AUG 11 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory HOLY CROSS
Location A A. Co.

18 (a) Funeral director Bernard C. Hulse

(b) Address 121 E West St

(c) Date of death AUG 10 1943

(d) Signature of registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 8 1943 2:50 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7-1-1943 to 8-8-1943.
and that I last saw her alive on 8-7-1943.Immediate cause of death
Carcinoma of BreastDuration
6 mo?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. J. Hall

Address 707 E. Fort Ave Date signed 8-9-43

07082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07082
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one year min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 10 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 330 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECTION. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07083
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1004 William St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 William St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-05-9406

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Mary A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1882

8. AGE: Years Months Days If less than one day

61 - 23 hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

12. Name Frank Barnes

13. Birthplace Md

14. Maiden Name Katie Raggen

15. Birthplace Md

16 (a) Informant Mrs Mary A Barnes

(b) Address 1004 William St

17 (a) Burial (b) Date thereof 8/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Baltimore Md

18 (a) Funeral director William M Marech

(b) Address 715 Ly St

19 (a) Date of death 10/10/43

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1943, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1943 to Aug 7 1943, and that I last saw him alive on Aug 7 1943.

Immediate cause of death Mitral Regurgitation

Duration

2 days

Due to Acute Dilatation of heart

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. H. Campbell

Address 1644 Hanover St

Date signed 8/11/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07084

Chiodi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07084

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

J. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3707 Gough St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Marie Poole

3 (b) If veteran, name war

3 (c) Social Security Account No. r

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 2 1905

8. AGE:

Years

Months

Days

If less than one day

37

10

7

hr.

min.

9. Birthplace

W. Va

(Town, county, and state)

10. Usual Occupation

Instructor

11. Industry or business

Haton Electric Co

FATHER

12. Name

Theo. Vinnick

13. Birthplace

Portland

MOTHER

14. Maiden Name

Catherine Stenyskowsky

15. Birthplace

Portland

16 (a) Informant

Mrs. Julia Kadosky

(b) Address

318 S Robinson St

17 (a)

Shipped

(b) Date thereof

7/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Cyriels Cem

Location

Olyphant Pa

18 (a) Funeral director

William M Marech

(b) Address

715 Light St

19 (a)

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/9/

1943 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1942, to 8/9/1943.

and that I last saw him alive on 8/9/1943

Immediate cause of death Renal Failure

Duration

Due to Acute Nephritis

Due to Septicemia

Other Conditions Ruptured Ectopic

Pneumonia - Pleurisy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

(over)

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Nathan E. Chisholm

Address

St. Joseph's Hosp

Date signed 8/9/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07085

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07085
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 36 E. Hamburg St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

John J. Dolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

June 22 1870

8. AGE:

Years

Months

Days

If less than one day

73

1

16

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

12. Name

James Dolan

13. Birthplace

Ireland

14. Maiden Name

Mary Reynolds

15. Birthplace

Ireland

16 (a) Informant Mr. Thomas Dolan (Bro)

(b) Address 36 E. Hamburg St

17 (a) Burial

(b) Date thereof 8/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

1041 Frederick Rd

18 (a) Funeral director

William M. Marek

(b) Address

715 E. 5th St

AUG 10 1943

Washington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

36 E. Hamburg St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 8

1943, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from May 1941 to 8/7/43 19

and that I last saw him alive on 8/7/43 19

Immediate cause of death

Arteriosclerotic Heart Dis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

8/14/43

8/14/43

8/14/43

8/14/43

8/14/43

8/14/43

8/14/43

8/14/43

8/14/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or item number correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439211
G 07086BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07086

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution **JONES HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1930 N Washington**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Minnie Dotterweich

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or
divorced **Widowed**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1879

8. AGE:

Years **64**

Months

Days

If less than one day

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Cook

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

**Records
JONES HOPKINS HOSPITAL**

17 (a)

Burial
(Burial, cremation, or removal)(b) Date thereof **Aug 12 1943**
(month) (day) (year)

(c) Cemetery or crematory

MorelandsLocation **Taylor Ave**

18 (a) Funeral director

Leah L. Cook

(b) Address

1701-103 N. Patt Park Ave

19

AUG 10 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug 8 1943** **1143 P**21. I certify that death occurred on the date above stated; that I attended
deceased from **Aug 6 1943** to **Aug 8 1943**
and that I last saw her alive on **Aug 8 1943**.

Immediate cause of death

**Subarachnoid
hemorrhage**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation **distended
left ventricle, large clot to
of autopsy: blood clot**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Abraham G. Levin**Address **Jones Hopkins Hospital** Date signed **7-8-43**

Duration

3 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

07087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07087

Registered No.

MJ-82924

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **4940 Eastern Ave.**
 (c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) **8 days**(e) Length of stay in Baltimore (yrs., mos., or days) **28 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County _____
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **913 W. Franklin St.**
 (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

Samuel Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Claudia Small

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

38? 1905

8. AGE:

Years

Months

Days

If less than one day

38**?****?**

hr.

min.

9. Birthplace **South Carolina**

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name **Andrew Smalls**13. Birthplace **South Carolina**14. Maiden Name **Phoebe ?**15. Birthplace **South Carolina**16 (a) Informant **BALTIMORE CITY HOSPITALS**(b) Address **(RECORDS)**17 (a) **Burial** (b) Date thereof **Aug. 10-43**

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn Cem**

Location

18 (a) Funeral director **Mr. Katie R. Williams**(b) Address **332 N. Sakonawake St.**19 (a) **Mr. Katie R. Williams, M.D.**

(Date received) Registrar

AUG. 10 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 7 1943 at 12:11 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **July 29 1943** to **August 7 1943**, and that I last saw him alive on **August 6 1943**.Immediate cause of death **Postoperative Relapsed Pneumonia**

Duration

2 daysDue to **Aspiration of secretion****3 days**Due to **Aspiration of secretion****2 days**

Other Conditions

over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: **Lower mass at pylorus - fainter of pneumonia of autopsy.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature **J. H. H.** Address **J. H. H.** Date signed **Aug. 7/43**

G 07088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07088

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1027 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1027 Edmondson Ave

(If rural give location)

(e) If foreign born, how long in U. S. A.

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-428. AGE: Years Months Days 25 If less than one day9 10 20

hr.

min.

9. Birthplace Bethesda, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George Pearson13. Birthplace Winnabow - S.C.14. Maiden Name Parthenia Millings15. Birthplace Winnabow - S.C.16 (a) Informant Mr. George Pearson(b) Address 1027 Edmondson Ave17 (a) Burial (b) Date thereof 9-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory mt. Zion

Location

18 (a) Funeral director Mr. Henry P. Phillips(b) Address 822 N. Charles St.19 (a) (b) Huntington Medical, Md.

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/91943 3 P M21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1943 to 8/9 1943 and that I last saw him alive on 8/9/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

1131 Harlem Ave

Date signed

VS 5

AUG 10 1943

G 07089

BALTIMORE CITY HEALTH DEPARTMENT

G 07089

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 5316 Tramore Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: md (b) County:

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No.: 5316 Tramore Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife: Minola Schiminger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 29-1888

8. AGE: Years Months Days

57

10

9

less than one day

hr.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

Frederick Schiminger

13. Birthplace

md

14. Maiden Name

15. Birthplace

16 (a) Informant

Minola Schiminger

(b) Address

5316 Tramore Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8/11/43
(month) (day) (year)

(c) Cemetery or crematory

Backwood

Location

Baltimore

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 - 1st St. Rd.

19 (a)

(b) Date of death

Aug 10 1943

(c) Signed by registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 1940, to Aug - 8 1943, and that I last saw him alive on May - 1 - 1943.

Immediate cause of death

Coronary Thrombosis.

Due to Coronary Thrombosis.

Generalized Intercerebral Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. Brooks Bayle

Address 5217 New York Rd.

Date signed 8/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

938 07090

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Green Spring + Belvedere

(c) Hospital or institution:

Helena Home for Aged + Infirmed(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County:(c) City or town: Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Green Spring + Belvedere

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Morris Levy

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1860

8. AGE: Years

83

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russian

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Louis Levy

13. Birthplace

Russian

14. Maiden Name

Sarah

15. Birthplace

Russian

16 (a) Informant

Agnes Bone

(b) Address

17 (a) Buried(b) Date thereof 8-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Windsor Hill Rd

Location

Same

18 (a) Funeral director

Joseph Louis Inc.

(b) Address

1439 E. Pratt St

19 (a)

(Date rec'd by registrar)

Therese Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1943, at 8 PM21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1943, to Aug. 9 1943, and that I last saw him alive on Aug 9 1943.

Immediate cause of death

Cerebral hemorrhage
Cardiovascular disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund L. KrumAddress Heimdale

Date signed

M. D.

PLEASE WRITE PLAINLY. WITH ONE ACTIVE SIGNATURE. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 10 1943

G 07091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07091

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1937 W. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MABEL BAKER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Divorced6 (b) Name of husband or wife Thomas P. Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct, 27, 1886

8. AGE: Years Months Days If less than one day

56911

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

FATHER
MOTHER12. Name Wm. R. Fardwell13. Birthplace Maryland14. Maiden Name Minnie E. Mac Glaughlin15. Birthplace Maryland16 (a) Informant Mrs. Minnie E. Fardwell(b) Address 1937 W. North Avenue17 (a) Burial (b) Date thereof Aug. 11-43
(Burial, cremation, or removal) (month) (day) (year)Loudon Park

(c) Cemetery or crematory

Baltimore, Maryland

Location

18 (a) Funeral director Burpee Funeral Home(b) Address 3621 Falls Road19 (a) AUG 10 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 43 1:45 P.M.

21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

Means of injury

23. Signature H. Z. W. Williams M.D.Date signed 8-9-43 Medical Examiner.

G 07092

BALTIMORE CITY HEALTH DEPARTMENT

G 07092

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

818 Hellington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

3 (a) FULL NAME

Mrs. Barbara E. Cakle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Charles E. Cakle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 14 - 1860

8. AGE:

Years

Months

Days

If less than one day

82

9

23

hr.

min.

9. Birthplace

Howard Co. Md.

(town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

12. Name

Food

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Charles E. Cakle

(b) Address

818 Hellington St.

17 (a) Burial

(b) Date thereof

Aug. 11 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

Burgee's Funeral Home

(b) Address

13631 Falls Road

AUG 10 1943

(b) Huntingdon Williams

VS 3

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

818 Hellington St.

(If rural city or town)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 7 - 1943 at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Aug 7 1943 and that I last saw her alive on Aug 6 1943.

Immediate cause of death

Congestive heart failure
Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edw. L. Glassman

M. D.

Address

4037 Falls Rd.

Date signed 8/10/43

EDW. L.

GLASSMAN

G 07093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07093

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3614 Elm Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

3 (a) FULL NAME

Mrs. Martha Virginia Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Jacob H. Bull

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 17-1868

8. AGE:

Years

Months

Days

If less than one day

75

4

22

hr.

min.

9. Birthplace

Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

FATHER
MOTHER

12. Name

Samuel F. Cox

13. Birthplace

Maryland

14. Maiden Name

Maggie Ports

15. Birthplace

Maryland

16 (a) Informant

James Earle Bull

(b) Address

1325 N. 41st Street

17 (a)

Funeral

(b) Date thereof

Aug 11-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Baltimore Co. Md.

18 (a) Funeral director

Burge Funeral Home

(b) Address

3631 Falls Road

19 (a)

Date of death

August 10 1943

(Date rec'd by registrar)

Huntington Hill, Baltimore, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3614 Elm Avenue

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 9-1943 at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1943 to Aug 9 1943 and that I last saw her alive on Aug 8 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

11 day.

Due to

Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. J. J. J. J.

Address

3614 Elm Avenue

Date signed

8/10/43

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 07094**

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) **4 days**

(e) Length of stay in Baltimore (yrs., mos., or days) **1 yr**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)

(d) Street No. **113 E. Monument**
 (If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

(a) FULL NAME **BERNARD THOMPSON**

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **M**

5. Color or race **B**

6 (a) Single, married, widowed, or divorced. **S**

5 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) **April 14, 1943**

8. AGE: Years Months Days If less than one day
3 1/2 25 hr. min.

9. Birthplace **Baltimore, Md.**
 (Town, county, and state)

10. Usual Occupation **infant**

11. Industry or business

12. Name **Joseph Thompson**

13. Birthplace **Baltimore**

14. Maiden Name **Mary Alexander**

15. Birthplace **Baltimore**

16 (a) Informant **Hospital records**

(b) Address

17 (a) **Burial** (b) Date thereof **8/10/43**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **St. Albans**
 Location

18 (a) Funeral director **Elroy Wilcox**

(b) Address **10007 Spoutley**

19 (a) **AUG 10 1943**
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 9 1943, at 4³⁰ AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **August 4 1943, to Aug 9 1943** and that I last saw him alive on **Aug 9 1943**.

Immediate cause of death
meningitis

Due to **tuberculosis**

Due to **miliary tuberculosis**

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy **same**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature **Margaret H. D. Smith**

Address **Sydenham Hospital** Date signed **8-9-43**

Duration
1 week

2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Little Sisters of the Poor
(b) Street address Valley & Preston Sts.
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of the Poor
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

John A. L. Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife Arieanna Loyd

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 1863

8. AGE: Years

79

Months

11

Days

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

retired

11. Industry or business

FATHER
MOTHER

12. Name John Amos

13. Birthplace France

14. Maiden Name Cecelia Audebert

15. Birthplace France

16 (a) Informant Miss. Maude E. King

(b) Address 3108 Walbrook Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/11/43

(month) (day) (year)

(c) Cemetery or crematory

Green Mount Cemy.

Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell Inc.

(b) Address 1900 Eutaw Place

19 (a)

(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Aug 8 1943, and that I last saw him alive on Aug 6 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

G. H. 2 Polite

Address

20 E. Preston St.

Date signed

M. D.

8/11/43

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AUG 10 1943

Dr. Blake

G 07096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07096
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1361* *Andrew St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

FREDERICK EADES

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

*w*6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1916

8. AGE:

Years

Months

Days

If less than one day

27

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *8-10-43*

(month) (day) (year)

(c) Cemetery or crematory

Location

St. Louis Mo

18 (a) Funeral director

Les S. G. G. G.

(b) Address

701-93 N. Pratt Park Ave

U 0 10 1943

(Date rec'd by registrar)

William Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 8, 1943 at 10 P. M.*

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *8-8-43 at about 7 P. M.*(b) Where did injury occur? *9 Terrace Ave, Long*(c) Did injury occur at home, on farm, industrial place, in public
place? *home* While at work? *no*(d) Means of injury - *fell down steps of home*23. Signature *W. J. Williams M.D.*Date signed *8-8-43*

07097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07097
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address: *Madison St. & London Ave*
 (c) Hospital or institution: *Maryland General Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *11*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Md.* (b) County: *Howard*
 (c) City or town: *Savage*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

*Melvin A.**Baker*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1898

8. AGE:

45

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual Occupation

Minister

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug. 13, 1943

(month) (day) (year)

(c) Cemetery or crematory

Location

Laurel, Md.

18 (a) Funeral director

Lloyd Kaiser, Inc.

(b) Address

Laurel, Md.

AUG 11 1943

(Date rec'd by registrar)

William M. P.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

*8/10/**1943, at 5:20 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *7/17* 1943, to *8/10* 1943, and that I last saw *him* alive on *8/10* 1943.

Immediate cause of death

*Intestinal Obstruction*Due to *Suppurative Peritonitis*Due to *Multiple liver abscesses*Other Condition: *Behring's Unborn of liver*

(Include pregnancy within 3 months of death)

Date of operation: *7/20/43*Major findings of operation: *Cholecystitis*of autopsy: *Causes of death above*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: *John D. Young, Jr.*Address: *Maryland General Hospital* Date signed: *8/19/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07098

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3304 Clifton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3304 Clifton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

MARGARET A HEIKES

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife George David Heikes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1854

8. AGE: Years Months Days If less than one day

89

2

1

hr.

min.

9. Birthplace Mechanicsburg, Pa.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Peter Westhafer

13. Birthplace Pa

14. Maiden Name Ann M. Stare

15. Birthplace Pa

16 (a) Informant Mrs. Catherine Lents

(b) Address 3304 Clifton Ave.

17 (a) Burial (b) Date thereof 8/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Chestnut Hill Cemetery

Location Mechanicsburg, Pa.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.

(b) Address North & Pa Aves. Baltimore Md.

AUG 11 1943 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1943 at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1943 to Aug 8, 1943, and that I last saw her alive on Aug 7, 1943.

Immediate cause of death Myocarditis

Due to arterio sclerosis advanced

Due to

Other Conditions Hypostatic pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Walter S. Williams

Address 222 Garrison

Date signed Aug 10, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

07099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07099

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married (widowed, or divorced)

6 (b) Name of husband or wife

6 (c) If alive, give age, -- years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery

Location

18 (a) Funeral director

(b) Address

AUG 11 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 2⁰⁰ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1943 to 8/8 1943, and that I last saw him alive on 8/8 1943.

Immediate cause of death

Lign and generalized arterial sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 8/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07100

83a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane

(c) Hospital or institution:

Cold Spring Nursing Home(d) Length of stay in hospital or inst. (yrs., mos., or days) 9(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1920 Sherwood Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Emil Croissant

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

September 10, 1872

8. AGE:

Years

Months

Days

If less than one day

7011-

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Unknown

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mrs. Agnes Dix

(b) Address

1920 Sherwood Ave17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8/11/43

(month) (day) (year)

(c) Cemetery or crematory

Moreland Park

Location

Taylor Ave

18 (a) Funeral director

Howard N. Blight, Jr.

(b) Address

4914 Belair Road19 (a) AUG 11 1943

(Date of death)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 101943, at 11:45 AM21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943, to Aug 10 1943, and that I last saw him alive on Aug 6 1943.

Immediate cause of death

cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. W. PuttermanAddress 7224 Reisterstown RdDate signed 8/10/43

07101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07101

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Clara -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1873

8. AGE:

Years

Months

Days

If less than one day

70

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

Joseph -

13. Birthplace

Russia

14. Maiden Name

Rachel -

15. Birthplace

Russia

16 (a) Informant

J. W. Colvin

(b) Address

1908 N. Pulaski St

17 (a) Burial, cremation, or removal

8-11-43

(c) Cemetery or crematory

St. Mary's Cemetery

Location

Ph. Rd.

18 (a) Funeral director

Joe Henry Inc

(b) Address

1439 G. Balto St

AUG 11 1943

VB 180

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1908 N. Pulaski St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10, 1943, 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1943, to Aug 10, 1943, and that I last saw him alive on Aug 10, 1943.

Immediate cause of death

Respiratory Failure

Due to

Pneumonia - primary - etiology not determined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dedore Shroff MD

Add

Balt City Hosp 8/10/43

07102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

07102

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1459 Light Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1459 Light Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Louis J Saloon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Eva Saloon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 - 18858. AGE: Years 58 Months 08 Days 18 If less than one day hr. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

FATHER

12. Name

Haris Saloon

13. Birthplace

Russia

MOTHER

14. Maiden Name

Fannie

15. Birthplace

Russia16 (a) Informant: Family

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8-11-43

(month) (day) (year)

(c) Cemetery or crematory

Andrew FriendshipLocation MD. Rd.

18 (a) Funeral director

Jace Lewis Inc

(b) Address

1839 E. Balt. St19 AUG 11 1943William H. Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1943 10 25 A M21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary
occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Medical Examiner.

Date signed August 10 1943

07103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07103

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution:

Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 613 Division St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Jessie Nichols

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

43 hr. min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

12. Name George Nichols

13. Birthplace N. C.

14. Maiden Name Sarah Kinsley

15. Birthplace N. C.

16 (a) Informant Mary Saunders

(b) Address 526 Satorage St

17 (a) (b) Date thereof 8-11-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cemetery

Location Baltimore Md.

18 (a) Funeral director Cephalad G. Yaddie

(b) Address 2101 Mt. Beulah St.

19 (a) AUG 11 1943

(b) Date of death Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1943, at 7:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1943, to Aug. 8, 1943, and that I last saw him alive on Aug. 8, 1943.

Immediate cause of death Uremia

Duration

Due to Cardio-renal disease

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C.R. Campbell

Address 718 Dolphin St. Date signed 8-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly.

07104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07104

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *2506 Rayner Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George H. Mason

3 (b) If veteran, name war

3 (c) Social Security Account

No. *220-01-1937*

4. Sex

M

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mozella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 10, 1883*

8. AGE: Years Months Days If less than one day

60 *5* *2* *26* hr. min.

9. Birthplace *Philadelphia Pa.*

(Town, county, and state)

10. Usual Occupation *unemployed*

11. Industry or business

12. Name *unknown*

13. Birthplace *Pa*

14. Maiden Name *unknown*

15. Birthplace *"*

16 (a) Informant *Mozella Mason*

(b) Address *2506 Rayner Ave*

17 (a) *Burial* (b) Date thereof *8-11-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Auburn*

Location *Baltimore Md.*

18 (a) Funeral director *Charles E. Cooper*

(b) Address *574 N. Calhoun St.*

19 (a) *AUG 11 1943* *Huntington Williams, M.D.*

(Date and by whom signed) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 6 1943* at *5:25 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-3* 19*43* to *8-6* 19*43*, and that I last saw him alive on *8-6* 19*43*

Immediate cause of death

Heart failure

Due to

Hypertensive Heart

Due to *disease*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Julius S. White*

Address *Provident Hospital* Date signed *8-9-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

116 N. Belmord Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 116 N. Belmord Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles J. Trabant

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-06-5878

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Margaret E. Trabant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 15-1975

8. AGE:

Years

Months

Days

If less than one day

67

7

242

hr.

min.

9. Birthplace

Balto. Md.

(town, county, and state)

10. Usual Occupation

Crops

11. Industry or business

12. Name

Albert Trabant

13. Birthplace

Germany

14. Maiden Name

Not known

15. Birthplace

Not known

16 (a) Informant

George Imperlein

(b) Address

116 N. Belmord Ave.

17 (a)

Burial

(b) Date thereof

Aug 16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Bur

Location

Belton Rd.

18 (a) Funeral director

John A. Miller

(b) Address

2334 Jefferson St.

19 (a)

AUG 11 1943

(b)

Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1943, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943, to August 8 1943, and that I last saw him alive on August 7 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Michael J. Dausch

M. D.

Address

2530 E. Baltimore St.

Date signed 8-10-43

Duration

1 day

Spec.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN BLOCK LETTERS. Physicians: please write the cause of death in full. correct age is especially important.

G 07106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07106

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3223 Elmley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3223 Elmley Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ETHA MAE WEBSTER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 212-09-3271

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife James F. Webster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1892

8. AGE: Years Months Days If less than one day

51

3

24

hr.

min.

9. Birthplace Pittsville Wicomico Co. Md.

(Town, county, and state)

10. Usual Occupation Housewife Saleslady

11. Industry or business Sears Roebuck Co

FATHER
MOTHER

12. Name George C. German

13. Birthplace Md

14. Maiden Name Mary L. Haddock

15. Birthplace Md

16 (a) Informant Mr. James F. Webster

(b) Address 3223 Elmley Ave.

17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof Aug. 12, 1943

(month) (day) (year)

(c) Cemetery or crematory Hebron Cem.

Location Hebron Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa Aves Balto Md.

19 (a)

AUG 11 1943

VS 156

(b)

Huntington Williams M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1943, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943, to 8-10 1943, and that I last saw him alive on 8-9 1943.

Immediate cause of death

Pneumonia

Duration

4 wks.

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

James Moore

Address

2105 Belair Rd

Date signed 8-11-43

M. D.

PLEASE WRITE PLAINLY, WITH OUPSIDING THE CAUSE OF DEATH. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07107
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2801 Baker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)(d) Street No. 2801 Baker St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

MILTON LEE DAVIS

3 (b) If veteran, name war
None3 (c) Social Security Account
No. ?4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Mary A. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 26, 1874

8. AGE: Years Months Days If less than one day
68 10 14 hr. min.9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business A. L. Stronberg

12. Name Thomas Davis

13. Birthplace Va

14. Maiden Name Eva Failford

15. Birthplace V

16 (a) Informant Mrs. Mary A. Davis

(b) Address 2801 Baker St.,

17 (a) Burial (b) Date thereof 8/13/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address Baltimore, Md.

19 (a) (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1943, at 3:20 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 5:45 1941 to August 10, 1943
and that I last saw him alive on August 10, 1943

Immediate cause of death

Pulmonary tuberculosis

Duration

6 mo.

Due to

Due to

Other Conditions

Diabetes mellitus
Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address 3803 Glen Dale Date signed 8/14/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 122 N. Highland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 122 N. Highland Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNA MARY SCHLOEGEL

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of husband or wife Edward F. Schloegel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1874

8. AGE: Years

69

Months

3

Days

13

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Joseph Wiessner

13. Birthplace Germany

MOTHER

14. Maiden Name Catherine Ulsch

15. Birthplace Austria

16 (a) Informant Mr. Edward F. Schloegel

(b) Address 122 N. Highland Ave.

17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Aves Baltimore, Md.

19 (a) AUG 11 1943 (b) Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Aug 9 1943 and that I last saw him alive on Aug 9 1943.

Immediate cause of death

Coronary Atherosclerosis

Due to

Due to Cardiac Arrhythmia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Tickner M. D.

Address P.O. Box 1000 Date signed 8/10/43

PLEASE WRITE PLAINLY, WITH CORRECTION. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07109

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave

(c) Hospital or institution:

Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Granite

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN SPENCER MULLICAN

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. ?

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife Effie May Mullican

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1877

8. AGE:

Years

Months

Days

If less than one day

66

2

26

hr.

min.

9. Birthplace Montgomery Co Md.

(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

12. Name Archibald Lewis Mullican

13. Birthplace Montgomery Co. Md.

14. Maiden Name Mary Frances Minnis

15. Birthplace Montgomery Co. Md.

16 (a) Informant Mr. Edward M. Mullican

(b) Address 3516 28th St. N.E. Wash. D. C.

17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Nealsville Presb. Cem.

Location Nealsville, Montgomery Co Md.

18 (d) Funeral director J. TICKNER & SONS INC.

(b) Address North & Pa Aves. Balto Md

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1943, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942, to Aug 9 1943 and that I last saw him alive on Aug 8 1943

Immediate cause of death

Carcinoma of the urinary bladder

Duration

2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Albert Mullican

23. Signature

Address 2302 Edmond St. Date signed 8/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07110
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2903 Baker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2903 Baker St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

BEULAH M. BUTLER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Eugene J. Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1868

8. AGE: Years

74

Months

7

Days

24

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name John W. Smith

13. Birthplace unknown

MOTHER

14. Maiden Name Rose

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. John Roddy

(b) Address 106 Lincoln Place Irvington N.

17 (a) Burial (b) Date thereof 8/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral Ce. n.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa Aves Baltimore, Md.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1943 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25, 1943, to August 10, 1943, and that I last saw her alive on August 10, 1943.

Immediate cause of death

1. Atherosclerotic Heart Disease

2. Embolus to Brain

Due to right leg

1. Thrombosis of right leg due to

Due to blood embolus.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leon Agelman

Address 1201 Poplar Ave St Date signed 8-10-43 M. D.

Duration

2 yr

2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07111
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2502 Wetherburn Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town 2502 Wetherburn Rd.

(If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ALICE J. HAASE

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Carl O. Haase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1895

8. AGE: Years Months Days If less than one day

47

8

13

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Insurance Solicitor

11. Industry or business Retired

12. Name Mr. Wm. H. Fiege

13. Birthplace Balto. Co. Md.

14. Maiden Name Jennie Amos

15. Birthplace Md.

16 (a) Informant Mr. Carl O. Haase

(b) Address 2502 Wetherburn Rd.

17 (a) Burial (b) Date thereof 8/12/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.

(b) Address North & Pa Aves Balto Md.

19 (a) AUG 11 1943 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1943 at 2:10 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 11/2/34 19 to 8/10/43 19

and that I last saw him alive on 7/4/43 19

Immediate cause of death
Hodgkin's Disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edwin B. Carroll
Address 11 E. Chase St., City signed 8/10/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFOLDING THE correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07112
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 W. Baltimore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2117 N. Baltimore St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD HARRY PEPPLER

3 (b) If veteran, name war
bone3 (c) Social Security Account
No. 1

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Thelma M. Peppler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1887

8. AGE: Years Months Days If less than one day

56

2

15

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Baltimore News-American

12. Name Louis Peppler

13. Birthplace Germany

14. Maiden Name Elizabeth Hoeflich

15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. Thelma M. Peppler

(b) Address 2117 W. Baltimore St.

17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SON INC.

(b) Address North & Pa. Aves. Baltimore Md.

19 AUG 11 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1943 1943. at 9 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 6, 1943, to Aug. 9, 1943,
and that I last saw him alive on Aug. 9, 1943.

Immediate cause of death

Coronary Thrombosis

Duration
2 daysDue to Intermittent
Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Oliver Langdon
Address 400 N. May St. Date signed 8/9/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.PLEASE WRITE PLAINLY, WITH CORRECTION. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

4 37970
G 07113BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46EG 07113
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **3608 Yolando Rd**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HARRY N. KILMAN JR

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. **None**

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED6 (b) Name of husband or wife **JOSEPHINE**6 (c) If alive, give age **45** years7. Birth date of deceased (mo., day, yr.) **9-25-79**8. AGE: Years Months Days If less than one day
63 10 15 hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

PROPRIETOR

11. Industry or business

Investigation Bureau

FATHER

12. Name **HENRY N. KILMAN**

13. Birthplace

Md

MOTHER

14. Maiden Name **SUSAN RICHARDSON**

15. Birthplace

Md

16 (a) Informant

RECORDS(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **8/13/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery **Druid Ridge**Location **Baltimore - Md**18 (a) Funeral director **Wm. H. Miller Sons**(b) Address **North & Paques**19 (a) **AUG 11 1943** (Date rec'd by registrar) Registrar **William H. Miller**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug 10** 19 **43**, at **6** **55** **A** **M**21. I certify that death occurred on the date above stated; that I attended deceased from **July 15** 19 **43** to **Aug 10** 19 **43**, and that I last saw him alive on **Aug 10** 19 **43**.

Immediate cause of death

RETROPERITONEAL ABSCESS

Duration

Due to **POST-OP INFECTION****FOLLOWING EXCISED****CA. OF SIGMOID**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: **CA. OF****SIGMOID**of autopsy: **RETROPERITONEAL ABSCESS**

PHYSICIAN

Underline the cause to which death should be charged, stating of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. H.

Address

Date signed **8/10/43**

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07114
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town 2235 St. Lukes Lane
(If outside city or town limits, write RURAL and give town)(d) Street No. Woodlawn Md.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Fred Morse FREDERICK B. MORSE

3 (b) If veteran, name war
none3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife No

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1925

8. AGE: Years Months Days If less than one day
18 5 0 hr. min.9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Ship Fitter

11. Industry or business Bethlehem Steel Co.

12. Name Frederick B. Morse

13. Birthplace Madison Wis.

14. Maiden Name Louise Smith

15. Birthplace Norfolk Va.

16 (a) Informant Mrs. Louise Campbell

(b) Address 2235 St. Lukes Lane Woodlawn Md.

17 (a) Burial (b) Date thereof 8/12/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.

(b) Address North & B a Baltimore, Md.

19 (a) 1943 (b)
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/43 19 43 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9/43 19 to 8/10/43 19 and that I last saw him alive on 8/10/43 19

Immediate cause of death

Pneumococcal meningitis

Due to

Complication of Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. F. Byers

Address St. Agnes Hosp Date signed 8/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland & Rayner

(c) Hospital or institution:

West Baltimore, General

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2730 Pennsylvania Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LydiaLUEDECKE

LYDIA L. LUEDECKE

3 (b) If veteran, name war
none3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Divorced6 (b) Name of husband or wife Walter Luedecke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1893

8. AGE:

Years

Months

Days

If less than one day

50

hr.

min.

9. Birthplace Switzerland

(Town, county, and state)

10. Usual Occupation Laundry11. Industry or business Urban Laundry12. Name Unknown13. Birthplace Unknown14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Mr. Walter Luedecke(b) Address 2730 Pennsylvania Ave.17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.Location Woodlawn Md.18 (a) Funeral director WM. J. TICKNER & SONS INC.(b) Address North & Pa Aves Baltimore, Md.19 (a) AUG 11 1943 (b)

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1943 at 4:30 AM21. I certify that death occurred on the date above stated; that I attended
deceased from Aug 8 1943 to 8/10/43
and that I last saw him live on 8/10/43

Immediate cause of death

Cardiac failure

Duration

Due to Rheumatic Cardiac diseaseDue to Renal failureOther Conditions Renal failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert New Hope Date signed 8/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every year correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07116

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07116

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Wilken & Caton Aves.*
 (c) Hospital or institution: *St. Agnes Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*
 (c) City or town *Pikesville*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *7029 Alden Rd.*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mrs. Margaret E. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John Gill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-14-90

8. AGE:

Years	Months	Days	If less than one day
<i>52</i>	<i>11</i>	<i>26</i>	<i>45</i> hr. min.

9. Birthplace

Maryland

10. Usual Occupation

At Home

11. Industry or business

12. Name *John T. Kelly*13. Birthplace *Ireland*14. Maiden Name *Mary Strohaber*15. Birthplace *Unknown*16 (a) Informant *John Gill Murphy*(b) Address *7029 Alden Road*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Aug. 12, 43*(c) Cemetery or crematory *Cathedral*Location *Baltimore, Maryland*18 (a) Funeral director *Ellsworth Amason*(b) Address *3911 Liberty Heights Ave.*19 *AUG 11 1943*(b) *Funeral Home*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 9 1943* at *3:10 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-4-1943* to *8-5-1943* and that I last saw her alive on *8-9-1943*.

Immediate cause of death *Thrombosis of abdominal aorta due to arteriosclerosis*

Due to

Due to

Other Conditions *ISCHEMIA*
Renal Ischemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place).

(e) Means of injury

23. Signature *James R. Dwyer*Address *St. Agnes Hospital* Date signed *8/11/43*

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

07118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07118

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 239 S. Regester Street
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 239 S. Regester Street
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

WLADYSLAW KRSTYNIK

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-03-7181

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Antonina6 (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) November 19, 1879

8. AGE: Years Months Days If less than one day

63819

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Cemetery12. Name Josef Krystyniak13. Birthplace Poland14. Maiden Name Antonina15. Birthplace Poland16 (a) Informant Mrs. Antonina Krystyniak(b) Address 239 S. Regester Street17 (a) Burial (b) Date thereof 8/12/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. StanislausLocation Mt. Carmel Road18 (a) Funeral director M. J. Sedzinski & Sons(b) Address 1808 Eastern Ave.19 AUG 11 1943 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1943 at 37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1943 to Aug. 8 1943, and that I last saw him alive on Aug. 4 1943.

Immediate cause of death

Streptococcus Tuberculosis (advanced)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____ (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
- (e) Means of injury _____

23. Signature Antonina KrystyniakAddress 2529 Eastern Ave. Date signed 8/10/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07119
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural) give location

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

64

8

2

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

(By registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1943, to Aug 10, 1944, and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 5, 1943

Major findings of operation:

Inguinal Cancer

of autopsy: under test

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 11 1943

Huntington Williams, M.D.

G 07120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07120

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1422 Caddox st.

(c) Hospital or institution:

None

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1422 Caddox street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANTON HODOSEK

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife Rose Hodosek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 - 1880

8. AGE:

Years 63Months 3Days 16

If less than one day

hr.

min.

9. Birthplace MURA KORONG, JUGOSLAVIA
(Town, county, and state)10. Usual Occupation CARPENTER

11. Industry or business

RETIRED

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden Name

unknown

15. Birthplace

unknown16 (a) Informant Rose Hodosek (Wife)(b) Address 1422 Caddox st.17 (a) Burial (b) Date thereof 8-13-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Cross A.A. Co.Location Brighton Md18 (a) Funeral director George R. Weber(b) Address 705-14 Blair st19 (a) (b)
(Date rec'd by registrar)

Registrar

ESTHER T. GUNN, Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1943 at 1 P. M21. I certify that death occurred on the date above stated; that I attended deceased from July 1 - 1943 until Aug. 10, 1943 and that I last saw him alive on Aug 10, 1943

Immediate cause of death

An aetia

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence Aug 10 at 1 P. M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William A. Scott M. D.Address 4815 Pennington Rd Date signed Aug 10, 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07122

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1629 W. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Ernest

Bill

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 30-438. AGE: Years Months Days If less than one day
4 9 hr. min.9. Birthplace Balts. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name Estey Boston15. Birthplace Balts. Md.16 (a) Informant Nella Boston
(b) Address 1629 W. Lexington St.17 (a) (b) Date thereof 8/11/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Int. Calvary Cmtg
Location Balts.18 (a) Funeral director Walter B. Spriggs(b) Address 134 W. Hamilton St.19 (a) 10711 1943
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1629 W. Lexington St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1943, at 9:25 P.M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Infantile
diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert C. Graham M.D.
Medical Examiner.Date signed August 10, 1943

438647 07123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G 07123

Registered No.

830

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Washington

(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)(d) Street No. 17 High St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Perry Strickler

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male white

5. Color of race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Rena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-83

8. AGE: Years 60 Months 2 Days 26 If less than one day hr. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Luther Strickler

13. Birthplace Va.

MOTHER

14. Maiden Name Francesa Raugee

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug-14-1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18 (a) Funeral director Fred W. Kraiss

(b) Address Hagerstown Md.

AUG 11 1943 (b) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1943 at 9:25

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1943 to Aug 11 1943 and that I last saw him alive on Aug 11 1943.

Immediate cause of death Subdural Hematoma

Duration

Due to unknown

7

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation July 28, 1943

Major findings of operation: Subdural Hematoma

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hugo L. Rypke

Address John Hopkins Hospital Date signed 8-11-43

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07124
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

IRWIN NICHOLS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Priscilla Nichols

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1901

8. AGE:

Years

Months

Days

If less than one day

42

hr.

min.

9. Birthplace Cambridge, Md.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Dunnock Nichols

13. Birthplace Cambridge, Md.

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Priscilla Nichols

(b) Address 1008 E. Lexington Street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/14/43

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly Ave.

19 (a)

AUG 11 1943

(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

6:40 A.

20. DATE OF DEATH August 11, 1943 at M

21. I certify that I took charge of the remains described above, held an
Autopsythereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia, lobes

Due to

Valvular heart disease
aortic stenosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature J. H. Wallenweber M.D.

Date signed 8-11-43

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07125

CERTIFICATE OF DEATH

C 07125

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Booth St St. Ward 4)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

2. FULL NAME Ida Virginia Slants

(a) Residence: No. 2121 Booth St St. Ward 4
(Usual place of abode)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

If U. S. Veteran specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Slants

6. DATE OF BIRTH (month, day, year) Sept 21-1888

7. AGE Years 54 Months 10 Days 19 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balt (State or country) md

13. NAME James E. Senne

14. BIRTHPLACE (city or town) Balt (State or country) md

15. MAIDEN NAME Mary J. Adams

16. BIRTHPLACE (city or town) Balt (State or country) md

17. INFORMANT Wm. F. Slants (Address) 2121 Booth St

18. BURIAL, CREMATION, OR REMOVAL Place London Pk. Date 8/14/43

19. UNDERTAKER Geo. L. Beyer Jr (Address) 1512 Hollins St

20. FILE NO. 1-1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 8/10 1943

22. I HEREBY CERTIFY, That I attended deceased from 8/1 1943 to 8/10 1943

I last saw him alive on 8/10 1943 Death is said to have occurred on the date stated above, at 5P

The principal cause of death and related causes of importance were as follows:

Malignancy of Breast

Other contributory causes of importance:

Was an operation performed? yes Date of about 8/1/43

For what disease or injury? Cancer of Breast

Name of operation Radical Mastectomy

What test confirmed diagnosis? Biopsy Others an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) William F. Slants

(Address) 1945 10 Balt

SHANAHAN

G 07126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07126

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind(b) County Baltimore(c) City or town Halatunga

(If outside city or town limits, write RURAL and give town)

(d) Street No. 124Sulphur Spring Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

JOHNY M. HAMPE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 20-1906

8. AGE:

Years

Months

Days

If less than one day

36

11

20

hr.

min.

9. Birthplace

Balt Md

(Town, county, and state)

10. Usual Occupation

Printer

11. Industry or business

Ford Balt Press

12. Name

John Hampe

13. Birthplace

Balt Md

14. Maiden Name

Theresa Kehman

15. Birthplace

Balt Md

16 (a) Informant

Catherine Hampe

(b) Address

211 Sulphur Spring Rd

17 (a)

Burial

(b) Date thereof

8/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Londondale Pk

Location

Balt Md

18 (a) Funeral director

Geo. H. Zentgraf

(b) Address

525 N. Lyndhurst St

19 (a)

(Date rec'd by registrar)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10 1943, at 12:50 PM

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

Syncope

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

8-10- at 12:50 PM

(b) Where did injury occur?

1500 Greenmount Ave

(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? yes

(d) Means of injury

fainted and fell to floor

23. Signature

H. W. Williams M.D.

Medical Examiner

Date signed

8-10-43

correct age is especially important

G 07127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07127
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month

(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1943, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1943, to 19, and that I last saw her alive on 19.

Immediate cause of death

Due to Brain tumor, 4th ventricle

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (burial, cremation, or removal)

(b) Date thereof (month) (day), (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

Date of death

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street Number

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 ¹³ at ^{10:50} M

21. I certify that death occurred on the date above stated; that I attended

deceased from Dec 19 ⁷² to Aug 19 ⁴³.

and that I last saw him alive on Aug 9, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 11 1943

VS 124

07129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07129

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3408 Ramona Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 3408 Ramona Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harold Jack Hurwig

3 (b) If veteran, name war

3 (c) Social Security Account

No. 578-01-0066

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Sarah Hurwig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16th 1943

8. AGE: Years Months Days If less than one day

35 10 23 hr. 1907 min.

9. Birthplace Massillon Ohio

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Cigarettes Distilling Co.

12. Name Clarence Hurwig

13. Birthplace Ohio

14. Maiden Name Ida Wenzel

15. Birthplace Ohio

16 (a) Informant Sara Hurwig

(b) Address 3408 Ramona Ave

17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Maryland Park

Location Parkville, Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) Date of registration (b) Registrar William

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1943, 6 A.M.

21. I certify that death occurred on the day above stated; that I attended deceased from March 1942 to Aug 9 1943, and that I last saw him alive on Aug 8 1943.

Immediate cause of death

Atrophic Scirrhous

Due to Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. S. Harding

Address 4812 Balis Rd Date signed Aug 9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CARE AND CORRECTNESS. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07130
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days) 1 day

3 (a) FULL NAME

Julia Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 9 1918

8. AGE:

25

Months

5

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Henry F. Miller

13. Birthplace Baltimore, Md.

14. Maiden Name Julia Lang

15. Birthplace Germany

16 (a) Informant Mrs. H. Miller

(b) Address 1026 Patapsco St.

17 (a) Burial (b) Date thereof Aug 13/43

(c) Cemetery or crematory location

Baltimore, Md.

18 (a) Funeral director Henry F. Miller

(b) Address 1426 E. Light St.

19 (a) AUG 11 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1026 Patapsco St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1943 at 9 P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy & Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

poisoning

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury August 8 1943 A.M.

(b) Where did injury occur? 1026 Patapsco Ave

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Ingestion of bromides

23. Signature Robert L. Graham M.D.

Date signed August 10 1943

G 07131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07131

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N caroline st.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(c) City or town

Balto. Md.

(d) Street No.

4303

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

JOHN A. SAPP

3 (b) If veteran, name war

3 (c) Social Security Account

No. ---

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or

divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, year)

11 30 1876

8. AGE: Years

67

Months

3

Days

10

If less than one day

hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Jacob Sapp

13. Birthplace

Baltimore Md.

14. Maiden Name

15. Birthplace

16 (a) Informant

Mrs. Clora X. Sapp

(b) Address

4303 Forrest View Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

13, 1943

(c) Cemetery or crematory

Moreland Pk.

Location

Balto. Co., Md.

18 (a) Funeral director

Flynn & Fleming

(b) Address

1426 Light St.

19 (a) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-10-1943, 10:10 PM

21. I certify that death occurred on the date above stated; that I attended

deceased from 8-10-1943, 8-10-1943,

and that I last saw him alive on 8-10-1943, 10:10 PM

Immediate cause of death

Cerebral hemorrhage

Duration

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

8-10-43

8-10-43

8-10-43

8-10-43

8-10-43

8-10-43

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8-10-43

8-10-43

8-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07132

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Sex *male* (b) County *Hartford*

(c) City or town *Forest Hill*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DWIGHT VAN HOY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *m*

5. Color or race *w*

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Angel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec 4 - 1919*

8. AGE: Years *24* Months *8* Days *7* If less than one day hr. min.

9. Birthplace

Ridgely Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *Preston Van Hoy*

13. Birthplace

NC

MOTHER

14. Maiden Name *Eva Waddell*

15. Birthplace

NC

16 (a) Informant *Mr Preston Van Hoy*

(b) Address *Forest Hill Rd*

17 (a) *Burial* (b) Date thereof *Aug 13 - 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Centre*

Location *Forest Hill Rd*

18 (a) Funeral director *Martha Sperry*

(b) Address *Carroll Ave*

19 (a) *Dr. J. H. Williams*
(Physician) (Name and address)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 11 1943 at 10:25 AM*

21. I certify that I took charge of the remains described above, held an *autopsy* thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Abuse of brain
Due to *Fracture of skull + nose*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *7-25-43* at *11:5* M.

(b) Where did injury occur? *Bellevue Rd near*

(c) Did injury occur at home, on farm, industrial place, in public place? *public* While at work? *no*

(d) Means of injury *Collision of auto car and*

23. Signature *H. J. Williams M.D.*
Medical Examiner.

Date signed *8-11-43* *Road rail*

G 07133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07133

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 624 W. Mulberry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 624 W. Mulberry St (If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Sydia Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Charles Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 17, 1943

8. AGE:

Years

Months

Days

If less than one day

60

1

22

hr.

min.

9. Birthplace

Rock Hall - Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Samuel Scott

13. Birthplace Rock Hall - Md

14. Maiden Name Rachel Thompson

15. Birthplace Rock Hall - Md.

16 (a) Informant

Marnie Sumner

(b) Address

624 W. Mulberry St

17 (a)

Burial

(b) Date thereof

Aug 12, 1943

(c) Burial, cremation, or removal

(month) (day) (year)

(c) Cemetery or crematory

Rock Hall

Location

Kent Co. Md

18 (a) Funeral director

Mrs Kate R. Williams

(b) Address

322 E. Schaeffer St

19 (a)

1943

(b) Date sent to registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1943, at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1942, to Aug. 9, 1943, and that I last saw her alive on Aug 9, 1943.

Immediate cause of death Cancer of Rectum

Due to Toxic Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 723 George

Date signed 9/10/43

Duration

1 yr

8 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

Social Security # 215-03-2623

07134

HEALTH DEPARTMENT—CITY OF BALTIMORE

07134

CERTIFICATE OF DEATH

93E

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 N. Lexington St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

Robert Boston

If U. S. Veteran

specify WAR

(a) Residence: No.

1616 N. Lexington St.

Ward.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. Color or Race C 5. Single, Married, Widowed, or Divorced (write the word) Widowed

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Victor Boston

6. DATE OF BIRTH (month, day, year)

May 3, 1880

7. AGE

Years 63

Months 3

Days 5

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Cecil Co.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

West River Md.

MOTHER FATHER

13. NAME

James Boston

14. BIRTHPLACE (city or town) (State or country)

West River Md.

15. MAIDEN NAME

Louise ?

16. BIRTHPLACE (city or town) (State or country)

West River Md.

17. INFORMANT

Doris Tisman

(Address)

1616 N. Lexington St.

18. BURIAL, CREMATION, OR REMOVAL

Placed in Memorial Aug 13 1943

19. UNDERTAKER

Mr. Katey R. Williams

(Address)

22nd & Schroeder St.

20. FILED

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 8, 1943

22. I HEREBY CERTIFY, That I attended deceased from

Aug. 7, 1943 to Aug. 8, 1943

I last saw him alive on Aug. 7, 1943 Death is said to have occurred on the date stated above, at 12 P. m.

The principal cause of death and related causes of importance were as follows:

Nephritis

Date of onset

Other contributory causes of importance:

Myocardial insufficiency

Was an operation performed?

Date of

For what disease or injury?

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so specify

(Signed)

C. R. Campbell

M. D.

(Address)

718 Dolphin St.

G 07135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07135

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 19 N. Vincent St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write full name and give town)

(d) Street No. 19 N. Vincent St (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert McGowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1887

8. AGE: Years 56 Months 2 Days If less than one day

hr. min.

9. Birthplace West River Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Samuel McGowan

13. Birthplace West River Md

14. Maiden Name Eliza Waters

15. Birthplace West River Md

16 (a) Informant Samuel McGowan

(b) Address 19 N. Vincent St

17 (a) Burial (b) Date thereof Aug 12-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs. Kate R. Wilson

(b) Address 922 N. Broadway St.

19 (a) 1943 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1943 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to Aug 9 1943 and that I last saw him alive on Aug 9 1943

Immediate cause of death

Duration

Congestive Heart Failure 2 months
Due to arteriosclerosis
Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Fresh W. Reckling Jr

Address 426 N. Broadway St Date signed 8/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07136

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07136

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

826 W 36th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Hannah J. Roach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female white

widowed

6 (b) Name of husband or wife

Andrew J. Roach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

March 12, 1861

8. AGE: Years

Months

Days

If less than one day

82

4

28

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name

Patrick Ballahan

13. Birthplace

Ireland

14. Maiden Name

Mary Magli

15. Birthplace

Ireland

16 (a) Informant

Charles F. Smith

(b) Address

826 W 36th St.

17 (a) Burial

(b) Date thereof

Aug 14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or

St. Marys

Location

Doraville

18 (a) Funeral director

Chenoweth & Sonoran

(b) Address

3615 17th Chestnut Ave

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

826 W 36th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 10, 1943, at 8³⁰ P. M.

21. I certify that death occurred on the date above stated; that I attended

deceased from Jan 12, 1943, to Aug 10, 1943,

and that I last saw him alive on Aug 9, 1943.

Immediate cause of death

Coronary Dilation

Due to

Heart Involvement

Due to

Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

3615 17th Chestnut Ave

Date signed 9/11/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly.

07137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07137
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive & 31st St.
- (c) Hospital or institution:
U. S. Marine Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
- (e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

3 (a) FULL NAME IRVING THOMAS BASIL

- 3 (b) If veteran, name war World's War
- 3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
- 6 (a) Single, married, widowed, or divorced: Married

- 6 (b) Name of husband or wife Mary Miller
- 6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1894

8. AGE: Years 48 Months 10 Days 28
- If less than one day hr min

9. Birthplace Annapolis, Md.
- (Town, county, and state)

10. Usual Occupation Printer
11. Industry or business Printer

12. Name Harry Basil
13. Birthplace Annapolis, Md.

14. Maiden Name Alice King
15. Birthplace Annapolis, Md.

- 16 (a) Informant Records, U.S. Marine Hospital
- (b) Address Baltimore, Md.

- 17 (a) Burial (b) Date thereof 8-13-43
- (c) Cemetery or crematory Baltimore Cemetery
- Location North Ave

- 18 (a) Funeral director A. Lee Odey
- (b) Address 4644 York Rd.

- 19 AUG 12 1943
- (Date rec'd by registrar) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore, Md.
- (If outside city or town limits, write RURAL and give town)
- (d) Street No. 3231 Lyndale Avenue
- (If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
- If yes, name country

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 9, 1943 at 1:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1943, to Aug. 9, 1943, and that I last saw him alive on Aug. 9, 1943.

Immediate cause of death Glioblastoma, multiforme, rt. temporo-parieto, occipital region, post op. & XXXX rad.

Duration
Approx. 18 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None this admission

of autopsy: None

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide No
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify kind of injury)

(e) Means of injury

23. Signature J. O. Odey

Address Baltimore, Md.

Date signed 8/9/43

PLEASE WRITE PLAINLY, WITH OR WITHOUT THE CAUSE OF DEATH CLEARLY AND LEGIBLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07138
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive & 31st St.
- (c) Hospital or institution:
U. S. Marine Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
- (e) Length of stay in Baltimore (yrs., mos., or days) 1/9 yr.

3 (a) FULL NAME DR. CHARLES H. GARDNER

3 (b) If veteran, name was

3 (c) Social Security Account
No.4. Sex
M5. Color or race
White6 (a) Single, married, widowed, or
divorced Married6 (b) Name of husband or wife Mrs. Kate S. Gardner
Maiden name (Shields) (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Aug. 13, 18648. AGE: Years Months Days If less than one day
78 11 28 hr. min.9. Birthplace Point Lookout, Md.
(Town, county, and state)10. Usual Occupation Physician & Sr. Surg. ret.11. Industry or business Above - retiredFATHER 12. Name Wm. E. Gardner
13. Birthplace Fayettesville, N.C.MOTHER 14. Maiden Name Sarah Ann Tarring
15. Birthplace Hagerstown, Md.16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.17 (a) Cremation (b) Date thereof Aug 12-43
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount
Location Greenmount & North18 (a) Funeral director A. Lee Oler(b) Address 4644 York Rd.19 (a) AUG 12 1943 (b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 106 W. University Parkway
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Aug. 10, 1943 at 2:00 M21. I certify that death occurred on the date above stated, that I attend-
ed deceased from Aug. 10, 1943 to Aug. 10, 1943
and that I last saw him alive on Aug. 10, 1943Immediate cause of death Myocardial
infarctionDuration
Unk.Due to Arteriosclerotic coronary
thrombosisApprox.
10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.of autopsy: No

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide No
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)
- (e) Means of injury

23. Signature LTJAddress Baltimore, Md.Date signed 8/10/43PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

7139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07139
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive & 31st St.
- (c) Hospital or institution:
U. S. Marine Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
- (e) Length of stay in Baltimore (yrs., mos., or days) ?

3 (a) FULL NAME LLOYD RIGGS

- 3 (b) If veteran, name war World's War
- 3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
- 6 (a) Single, married, widowed, or divorced. Wid.

- 6 (b) Name of husband or wife Marja ? (deceased)
- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 13, 1893

8. AGE: Years 49 Months 11 Days 25 28 hr. min.

9. Birthplace Pontiac, Ill.
- (Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Miles Riggs

13. Birthplace Ill.

14. Maiden Name Anna ?

15. Birthplace Erickson, Ill.

- 16 (a) Informant Records, U.S. Marine Hospital

- (b) Address Baltimore, Md.

- 17 (a) Burial (b) Date thereof 8-13-43.

- (c) Cemetery or crematory Arlington National

- Location Arlington, Va.

- 18 (a) Funeral director A. Lee Oeder.

- (b) Address 4644 York Rd.

- AUG 12 1943 (Date rec'd by registrar) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
- (If outside city or town limits, write RURAL and give town)
- (d) Street No. 1414 Eutaw Place
- (If rural give location)
- (e) Citizen of foreign country? NO (Yes or No)
- If yes, name country

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 11, 1943, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27, 1943, to Aug. 11, 1943, and that I last saw him alive on Aug. 11, 1943.

- Immediate cause of death Advanced atrophic cirrhosis of the liver

Duration
Several
years

Due to

Due to

- Other Conditions Marked edema & congestion, both lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide NO

- (b) Date of occurrence at M

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, or public place? While at work?

- (e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/11/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓
161a G 07140
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

AUG 12 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-11-1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-1943 to 8-11-1943,

and that I last saw him alive on 8-11-1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE IN PRINT. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07141
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

702 W. Redwood St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

702 W. Redwood St.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

3 (a) FULL NAME

Baby Girl Boone

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

None

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-9-43

8. AGE:

Years

Months

Days

If less than one day

1 hr.

15 min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Frank Coats

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden Name

Edna Boone

15. Birthplace

Baltimore Md.

16 (a) Informant

Edna Boone

(b) Address

702 W. Redwood St. Balto Md.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL AUG 11 1943

18 (a) Funeral director

Huntington Williams, M.D.

(b) Address

19

AUG 12 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-9

19 43

at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-43 to 8-9-43 and that I last saw her alive on Aug 9 1943.

Immediate cause of death

Pulmonary Atelectasis

Due to

Abortion 20 wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Huntington Williams, M.D.
Community Hospital
Baltimore, Md.
Signed 8/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07142

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07142
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Greene + Redwood*
- (c) Hospital or institution: *University Hosp.*
- (d) Length of stay in hospital or inst. (yrs., mos., or days) *3 mo*
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *md.* (b) County
- (c) City or town *Baltimore*
(If outside city or town limits, write R.U.R. and give town)
- (d) Street No. *533 Castle Street*
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Vincent Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1876

8. AGE:

Years

Months

Days

If less than one day

67

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Old job.

11. Industry or business

12. Name

Charley Thomas

13. Birthplace

Maryland

14. Maiden Name

E. Liza Thomas

15. Birthplace

Maryland

16 (a) Informant

E. Liza Thomas

(b) Address

533 Castle Street

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

JOHN HOPKINS MEDICAL SCHOOL AUG 11 1943

18 (a) Funeral director

Thurston Williams, M.D.

(b) Address

*Thurston Williams, M.D.**AUG 12 1943*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 13 1943 at 4:45 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *4-19 1943* to *7-19 1943*, and that I last saw him alive on *July 13 1943*.

Immediate cause of death

*Congestive heart failure*Due to *Hypertensive**Cardio-Vascular disease*

Due to

Other Conditions *Old monoplegia of left leg.*

(Include pregnancy within 8 months of death)

Date of operation *None*

Major findings of operation: —

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

*H. B. Hagano*Address *Univ. Hosp.*Date signed *7/3/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians; please write the causes of death clearly and legibly, correct age is especially important.

07143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07143

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Pyram Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Stanislaus Bajaraki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years

Months

Days

If less than one day

55-60?

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 12 1943

VS 151

0284

MEDICAL CERTIFICATION

20. DATE OF DEATH

7-26-

1943, at

5 P

M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractures skull

Due to

Other Conditions

Multiple bruises, breast bones
laceration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-26-43 at

(b) Where did injury occur?

Carroll Park R.R. Tracks

(c) Did injury occur at home, on farm, industrial place, in public place? Public

While at work?

No

(d) Means of injury

Probably fell down embankment

23. Signature

Howard J. Chalmers

M.D.

Date signed 7-30-43

MARSHALL JONES.

07144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓

G 07144

122a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date of death)

(b)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943. 8/10 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1943 to 8/10 1943 and that I last saw him alive on 8/10 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

7145

MJ-82810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07145
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2122 Penna Ave.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Bohannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

Colored

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 24, 1906

8. AGE:

Years

Months

Days

If less than one day

36

7

15

hr.

min.

9. Birthplace

Kentucky

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name James

13. Birthplace

Kentucky

14. Maiden Name

Kate Harris

15. Birthplace

Kentucky

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 8/13/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/9

19 43 at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 19 43 to 8/7 19 43.

and that I last saw him alive on 8/9 19 43

Immediate cause of death

Pulmonary T.B. - lateral & cavitation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Searman

Address

B. C. H.

Date signed

7/11/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G 07146
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

President Hospital 16-15-47

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ma (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1108 N. Carey St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female Negro

5. Color or race

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 57 Months 3 Days 4 If less than one day hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 12 1943

(c) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1943 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1943, to Aug 10 1943, and that I last saw her alive on Aug 10 1943.

Immediate cause of death

Myocardial Heart Disease

Due to

Due to

Other Conditions Chronic Nephritis +

Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature G. S. Davies

Address Provident Hospital

Date signed 8-11-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX G 07147
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4702 Harford Road
- (c) Hospital or institution: Harford Convalescent Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 MOS
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Linthicum, Md.
(If outside city or town limits, write RURAL and give town)
- (d) Street No. Maple & Catalpha Roads
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Beck

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 21, 1881

8. AGE:

Years

Months

Days

If less than one day

62

1

20

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Housekeeper

11. Industry or business

12. Name

Philip Beck

13. Birthplace

Germany

14. Maiden Name

Mary Horisberg

15. Birthplace

Harrisburg, Pa.

16 (a) Informant Mrs. John M. Robinson

(b) Address 2903 Dunran Rd., Dundalk, Md.

17 (a) Burial

(b) Date thereof Aug. 12, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

London Park Cemetery

Location

Baltimore, Md.

18 (a) Funeral director

W. Baltimore St.

19 (a)

(b)

(Date rec'd by registrar)

Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10 1943 at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1943, to Aug 10, 1943, and that I last saw her alive on Aug 10, 1943.

Immediate cause of death

Chronic myocarditis

Duration

15 yrs

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Terminal uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. V. Harbold M.D.

Address 4706 Harford Road

Date signed 8/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every year or more information is especially important. Physicians: please write the causes of death clearly and legibly.

G 07148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07148
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-05-4688

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

at 56

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10 1948, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942, to Aug 10 1948, and that I last saw him live on Aug 9 1948.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

1948
10 days5 yrs
2 yrs

3 yrs

Physician

Underline the cause to which death should be charged statistically.

AUG 12 1948

07149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07149

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 7:01 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1943, to 8/11 1943, and that I last saw him alive on 8/11 1943.

Immediate cause of death

Pulmonary Edema.
Acute Heart Failure
Due to Arteriosclerosis &
Hypertension C.V.D.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH CORRECT AND FULL NAMES. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07150

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital 4-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

3 (a) FULL NAME

(Billie) Miller, William Donald

3 (b) If veteran, name war

3 (c) Social Security Account
No. no

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day
10 4 14 13 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date of death

(b) Date of death

18 (a) Funeral director

(b) Address

19 (a)

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 9 1943 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1943, to 8/9 1943, and that I last saw him alive on 8/9 1943.

Immediate cause of death

Heart failure

Due to

Rheumatic fever

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AUG 12 1943

Huntington Williams, M.D. Registrar

Address

Date signed 8/9/43

G 07151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07151

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring + Belvedere

(c) Hospital or institution:

Hebrew Home for Aged + Infirmed(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. Green Spring + Belvedere
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Goldie Braustein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white6 (a) Single, married, widowed, or divorced.6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 80 Months Days If less than one day
hr. min.9. Birthplace Russian
(Town, county, and state)10. Usual Occupation None

11. Industry or business

12. Name Moses13. Birthplace Russian14. Maiden Name Bonnah15. Birthplace Russian16 (a) Informant Louis Braustein(b) Address 518 W. Franklin St17 (a) burial (b) Date thereof 8-12-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory RosevaleLocation Phel Rd + Hamilton Ave18 (a) Funeral director Jack Young(b) Address 1439 E. Baltimore

19 (a) (b) Registrar

AUG 12 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1943, at 4 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 12/25/1938 to 8/10/1943, and that I last saw her alive on 8/10/1943.Immediate cause of death Ch. card. vas. disease
Permeous anemia

Duration

1932

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Edmund HurmAddress LevendaleDate signed 8/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07152
 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **Wyman Park Drive & 31st St.**
 (c) Hospital or institution:
U. S. Marine Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **Since July 16, 1943**
 (e) Length of stay in Baltimore (yrs., mos., or days) **Since July 16, 1943**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **Harroll**
 (c) City or town **Westminster**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **50 Bond Street**
 (If rural give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

3 (a) FULL NAME **ROY JOHN CALVIN LEESE**

3 (b) If veteran, name war **World's War** 3 (c) Social Security Account No.

4. Sex **M** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Mary Nicodemus**
 6 (c) If alive, give age **50** years

7. Birth date of deceased (mo., day, yr.) **Jan. 29, 1889**

8. AGE: Years **54** Months **6** Days **14** If less than one day hr. min.

9. Birthplace **Adams County, Pa.**
 (Town, county, and state)

10. Usual Occupation **Salesman-International Harvester**

11. Industry or business **ter co.**

12. Name **John H. Leese**

13. Birthplace **Pa.**

14. Maiden Name **Senora E. Foreman**

15. Birthplace **Pa.**

16 (a) Informant **Records, U.S. Marine Hosp.**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **Aug. 15-43**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Linganze Cem.**
 Location **Frederick, Md.**

18 (a) Funeral director **F. Francis Rusey**

(b) Address **Westminster, Md.**

19 (a) **Aug 12, 1943** (b) **Washington Williams**

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **August 12, 1943, at 8:15 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **July 16, 1943, to August 12, 1943** and that I last saw him alive on **Aug. 12, 1943**

Immediate cause of death **Arteriosclerotic heart disease**

Duration **Unk.**

Due to

Due to

Other Conditions **Embolism, arterial**

Unk.

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operations:

of autopsy: **None**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **C. S. B. S. S.**

Address **Baltimore, Md.** Date signed **8/12/43**

Va-13433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07153
AB-81973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07153
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) **26 Mo.**
(e) Length of stay in Baltimore (yrs., mos., or days) **22 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3509 E. Fairmount Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ella Mae Schuette

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
F

5. Color or race
W

6 (a) Single, married, widowed, or divorced
Married-Separated

6 (b) Name of husband or wife **William**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Dec. 17-1890**

8. AGE: Years Months Days If less than one day
52 7 26 25 hr. min.

9. Birthplace **West Virginia**

(Town, county, and state)

10. Usual Occupation **Lives at home**

11. Industry or business

12. Name **James Cook**

13. Birthplace **W. Va.**

14. Maiden Name **Elenora Mobley**

15. Birthplace **W. Va.**

16 (a) Informant **Baltimore City Hospitals**

(b) Address **Records**

17 (a) **Burial** (b) Date thereof **8-16-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **St. James Ferry**
Location **St. James Ferry, Md.**

18 (a) Funeral director **Geo. H. Schaub**

(b) Address **2191 Frederick Avenue**

(c) Address **2191 Frederick Avenue**
(Date rec'd by registrar) **August 12, 1943**

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-12-1943 at 7:30 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **6-11-1943** to **8-12-1943**, and that I last saw him alive on **8-12-1943**.

Immediate cause of death

Duration

Generalized Carcinomatosis
Due to **Site of origin undetermined** **4 mos.**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature **Donald B. Heft**
Address **Baltimore City, Md.** Date signed **8-12-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07154

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

AUG 12 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1943 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1943 to 8/10 1943 and that I last saw her alive on 8/10 1943

Immediate cause of death

Toxemia
Due to Intestinal
ObstructionDue to Carcinoma
Intestine

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/10/43

Major findings of operation: Transverse colon
of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct and legible. Physicians: please write the causes of death clearly and legibly.

G 07155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07155

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: *Maryland General Hosp.*
(c) Hospital or institution: *Baltimore, Md.*
(d) Length of stay in hospital or inst. (yrs., mos., or days): *8*
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Md.* (b) County: *Baltimore*
(c) City or town: *Baltimore* (If outside city or town limits, write RURAL and give town)
(d) Street No.: *1524*
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country:

3 (a) FULL NAME: *Baby Girl Trainor*

3 (b) If veteran, name was: 3 (c) Social Security Account No.

4. Sex: *F* 5. Color or race: *W* 6 (a) Single, married, widowed, or divorced: *Unborn*

6 (b) Name of husband or wife: 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): *8-10-43*

8. AGE: Years Months Days If less than one day
5 hr. *38* min.

9. Birthplace: *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name: *Robert A. Trainor*

13. Birthplace: *Phila. Pa.*

14. Maiden Name: *Mary De Lea*

15. Birthplace: *Baltimore, Md.*

16 (a) Informant: *Hospice Robert*

(b) Address

17 (a) *Burial* (b) Date thereof: *8/25/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: *Holy Redeemer*

Location

18 (a) Funeral director: *C. Vernon Zimmerman*

(b) Address: *1611 Oak St. N.Y.C.*

19 (a) (b) Registrar

(Date rec'd by registrar) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *8-10-43* 19 *at 6:55 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-10-43* 19 *to 8-10-43* 19
and that I last saw her alive on *8-10-43* 19

Immediate cause of death

*Pulmonary obstruction
& embolism - Secondary pneumonia*

Due to *Pneumonia*

Due to *Atelactasis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: *Thomas C. Wilster*

Address: *Maryland General Hospital* Date signed: *8-10-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

Aug 12 1943

G 07156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07156

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JONES HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Paulette Corbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **3-31-43**

8. AGE:

Years

Months

Days

If less than one day

4**8**

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Benjamin Corbin

13. Birthplace

MOTHER

14. Maiden Name

Katherine Prather

15. Birthplace

16 (a) Informant

(b) Address

Records JONES HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Aug. 12, 1948

(c) Cemetery or crematory

Location

Debuter High St. Baltimore Co. Md.

18 (a) Funeral director

(b) Address

Mr. Geo. H. Holland 1631 Duval St. Baltimore, Md.

19 (a)

AUG 12 1948

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **md.**

(b) County

Baltimore

(c) City or town

Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7 South Lane

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 9 1948 at 6:15 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death **Respiratory****failure**

Duration

7

Due to

Toxemia

Due to

pneumonia

Other Conditions

md

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert Kaye

Address

1631 Duval St. Baltimore, Md.

Date signed

8/12/48

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING AND CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

G 07157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07157
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4622 Asbury Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4622 Asbury Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

MARY C. NORTRUP

3 (b) If veteran, name war

3 (c) Social Security Account

No. --

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

femalewhitewidowed6 (b) Name of husband or wife John H. Nortrup

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1859

8. AGE:

Years

Months

Days

If less than one day

64019

hr.

min.

9. Birthplace Balto. Co., Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER12. Name Joseph Meier13. Birthplace Germany14. Maiden Name Wilhelmina Schwarz15. Birthplace Germany16 (a) Informant Mrs. Botzen(b) Address 4622 Asbury Ave.17 (a) burial (b) Date thereof Aug. 13, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak LawnLocation Balto., Md.18 (a) Funeral director Kassner Funeral Home(b) Address 7401 Belair Road(c) Huntington WilliamsUG 12-1943
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10th 19 43 at 1:32 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 19 43, to Aug 10 19 43 and that I last saw her alive on Aug 9 19 43.

Immediate cause of death.

Acute Cardiac Dilatation

Due to

Ch 1 by infarction

Due to

Atherosclerosis

Other Conditions

Gout arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. S. HardingAddress 7401 Belair RdDate signed Aug 11/43

Duration

7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07158

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19-12-1943

(Death rec'd by registrar)

VB 144

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/9

1943, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1943 to 8/9 1943, and that I last saw him alive on 8/9 1943.

Immediate cause of death

Post operative shock

Due to acute cholelithiasis

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 8/9/43

Major findings of operations:

acute cholelithiasis

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address St. Agnes Hosp

Date signed 8/9/43

Duration

8 hours

2 weeks

10 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is especially important. Physicians: please write the cause of death clearly and legibly.

G 07159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 07159

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Balt. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Balto.

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 16

Central Avenue

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ida

Kodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

W

5. Color or race

F

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Joseph Kodman

(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

June 18 - 1900

8. AGE:

Years

Months

Days

If less than one day

43

1

22

hr.

min.

9. Birthplace

Sparks Pt. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Stephen H. Kautowicz

13. Birthplace

Poland

MOTHER

14. Maiden Name

Anna Kierzencki

15. Birthplace

Poland

16 (a) Informant

Victor Kodman

(b) Address

Turners Station

17 (a)

Burial

(b) Date thereof

Aug 14 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Hill

Location

German Hill Rd.

18 (a) Funeral director

John S. Connolly

(b) Address

1800 E. Enoch Ave.

19 (a)

2. 1943

Thurston Williams

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 10, 1943, at 7:25 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy

thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bronchopneumonia

Subacute nephritis

Due to

Other Conditions

Coma due to carbon

monoxide poisoning

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 23 1943 4 P.M.

(b) Where did injury occur? 16 Central Ave

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Inhaled gas from oven

23. Signature Robert H. Graham M.D.

Date signed

Aug. 10 1943

G 07160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07160

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *North Broadway*

(c) Hospital or institution:

Commodore Home and Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2*(e) Length of stay in Baltimore (yrs., mos., or days) *13 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *Baltimore*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *711 S. Broadway St.*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

KAVAR, HARRY

3 (b) If veteran, name war

Yes, World War I

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

(HARRISON)

6 (c) If alive, give age

44 years

7. Birth date of deceased (mo., day, yr.)

6-16-1892

8. AGE:

Years

Months

Days

If less than one day

*51**21**24*

hr.

min.

9. Birthplace

Prussia

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

Kavar

13. Birthplace

Germany

14. Maiden Name

Kavar

15. Birthplace

Germany

16 (a) Informant

Mrs. Edna Kavar

(b) Address

1711 S. Broadway St.

17 (a)

Burial

(b) Date thereof

Aug 13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Balto. Natl.

Location

Frederick Rgn.

18 (a) Funeral director

John G. Connelly

(b) Address

414 Eastern Ave. Eves.

19 (a)

John Williams, M.D.

(b) Signature

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 10, 1943, at 8:45 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *8-10* 1943, to *8-10* 1943, and that I last saw him alive on *8-10-1943*

Immediate cause of death

Cerebral hemorrhage

Due to

hypertension and arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

*Isabella Harrison*Address *Church Home & Hospital*Date signed *8-10-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information concerning age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07161
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correctness. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Alameda St

(c) Hospital or institution

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William P Jackson

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. 219-05-7499

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or

divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

39 0 27

If less than one day

hr. min.

9. Birthplace

Howard County

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

16 (b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date of death)

(b) Registrar

AUG 12 1943

VS 148

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Howard

(c) City or town

Ellicott City, Md

(d) Street No.

Frederick Road

(e) Citizen of foreign country?

If yes, name country

(If rural give location)

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1943, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1943, to Aug 6 1943, and that I last saw him alive on Aug 6 1943.

Immediate cause of death
Hypertensive Heart
Disease

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operationsof autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury
23. Signature H. J. Gaudin
Address Provident Hospital Date signed 8/8/43

Duration

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

G 07162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07162
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) General director

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 10

1943

at 1

M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1943 to Aug 4 1943; and that I last saw him alive on Aug 8 1943

Immediate cause of death

acute heart failure

Due to Pulmonary Congestion

Due to Chronic myocarditis

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M/D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or item of information is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07163

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 843 S. Kenwood ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

John Kawalewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Catherine - Katuray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1870

8. AGE: Years

73

Months

Days

If less than one day

hr. 7 min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

John Kawalewski

13. Birthplace

Poland

14. Maiden Name

unknown

15. Birthplace

Poland

16 (a) Informant Mrs Catherine Kawalewski

(b) Address 843 S. Kenwood ave

17 (a) Burial

(b) Date thereof 8/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

Baltimore City

18 (a) Funeral director

John M. Willey

(b) Address

404 S. Chester Street

19 (a) AUG 12 1943

(b) Huntington Williams

(Date rec'd by registrar)

(Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 843 S. Kenwood ave

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1943 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Aug 11 1943, and that I last saw him alive on Aug 11 1943.

Immediate cause of death

Coronal Hemorrhage

Due to

Due to arterio Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Willam. Roaver D.

Address 801 S. Kenwood Ave Date signed 8/14/43

Duration

8/1/43

1935

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

107164 *Height* *Dr. A. A. Weinstein* 107164
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH *937*

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *948 Ashland Court*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) *10*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *948 Ashland Court*
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Leila J. Washburn*
3 (b) If veteran, name war *NV* 3 (c) Social Security Account No. *None*
4. Sex *F* 5. Color or race *W.* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Wymon F.*
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) *Oct 18-1879*
8. AGE: Years *63* Months *9* Days *24* If less than one day hr. min.
9. Birthplace *Bethlehem Delaware*
(Town, county, and state)
10. Usual Occupation *Housewife*
11. Industry or business
12. Name *John B. English*
13. Birthplace *Delaware*
14. Maiden Name
15. Birthplace
16 (a) Informant *Wymon F. Washburn*
(b) Address *948 Ashland Court*
17 (a) *Burial* (b) Date thereof *Aug 13 1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Woodlawn*
Location *Baltimore*
18 (a) Funeral director *Wm. C. Cook Inc.*
(b) Address *1217 St Paul, Balto*
AUG 12 1943
Date of death by registrar *August 11 1943* Registrar *Dr. A. A. Weinstein*

MEDICAL CERTIFICATION
20. DATE OF DEATH *8/11* 19*43*, at *9:00* M
21. I certify that death occurred on the date above stated; that I attended deceased from *May* 19*43*, to *Aug 11* 19*43* and that I last saw h.c. alive on *June* *1943*
Immediate cause of death
Arterio-sclerotic C.V. Disease
Due to *Coronary Thrombosis*
Due to
Other Conditions *Cerebral Embolism*
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature *Alex. A. Weinstein*
Address *713 Asquith St.* Date signed *8/11/43*

Duration
Two years
2 mos
1 min
PHYSICIAN
Underline the cause to which death should be charged statistically.

G 07165

BALTIMORE CITY HEALTH DEPARTMENT

G 07165

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 084-14-633

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1943, to August 10, 1943, and that I last saw him alive on Aug 10, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 2107 Park Ave Date signed 8/11/43

Duration

1-2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 929 N. Linwood Ave
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md (b) County
 (c) City or town Balto
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 929 N. Linwood Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Adeline M. Gill
 3 (b) If veteran, name war No
 3 (c) Social Security Account No. NONE

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed
 6 (b) Name of husband or wife William P. Gill Sr
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1856
 8. AGE: Years 87 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Balto Md
 (Town, county, and state)
 10. Usual Occupation Medical Nurse
 11. Industry or business Self

12. Name (Known) Mitchell
 13. Birthplace Md.
 14. Maiden Name
 15. Birthplace

16 (a) Informant Harry Linzey
 (b) Address 4300 Powell Ave

17 (a) Burial (b) Date thereof 8/11/43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematorium Oak Lawn
 Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc
 (b) Address 1217 St. Paul St

19 (a) (b)
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH Aug 11th 1943 3⁴⁵ P. M.
 21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1943 to 8/11 1943 and that I last saw him alive on 8/11 1943.

Immediate cause of death SENILITY
 Due to
 Due to (SENILE PSYCHOSIS)
 Other Conditions ARTERIO SCLEROSIS MYOCARDIAL DEGENERATION
 (Include pregnancy within 3 months of death)
 Date of operation
 Major findings of operations
 of autopsy:

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury
 23. Signature John A. Machen
 Address 6304 Belair Rd Date signed 8/12/43

Duration
 3 YRS.
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07167

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 726 E. North Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 90 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 726 E. North Ave
(If rural give location)(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

George W. Sorter

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Annie E. Sorter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 18498. AGE: Years 94 Months 3 Days 9 hr. min.9. Birthplace Cincinnati Ohio
(City, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Builder12. Name Daniel Webster Sorter13. Birthplace Balto Md.14. Maiden Name Belinda Lockwood15. Birthplace Balto. Md.16 (a) Informant Carrie E. Smith(b) Address 2206 Cecil Ave17 (a) Funeral (b) Date thereof 8/10/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Green MountLocation Gatthers Md18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul St19 (a) AUG 12 1943 (b) William Cook Inc
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th 1943 9:30 M21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Aug 10 1943, and that I last saw him alive on Aug 10 1943

Immediate cause of death

Cerebral hemorrhageDue to Generalized Arteriosclerosis

Due to

Other Conditions Senile Psychosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Nathaniel M BeckAddress 2727 N Charles St signed Aug 11-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07168

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2831 Harlem Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Wesley

Harvey

Clag.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 717-07-1334

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1943, at 12²⁵ P. M.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Lustine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1889

8. AGE: Years 54 Months 2 Days 23 22 hr. min.

9. Birthplace Manchester Md.
(Town, county, and state)

10. Usual Occupation Property Clerk

11. Industry or business

12. Name Charles Clag

13. Birthplace Md.

14. Maiden Name Margaretta Thiriot

15. Birthplace Md.

16 (a) Informant Carroll Mitchell

(b) Address 1712 E 32nd St

17 (a) Burial, cremation, or removal

(b) Date thereof 8/14/43

(c) Cemetery or cremation location Baltimore

18 (a) Funeral director William J. Jones

(b) Address 1219 1st Ave S

19 (a) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Deep lacerations right arm

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/11/43 at 10:30 A. 16-6 M.

(b) Where did injury occur? 2831 Harlem Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Fell through plate glass

23. Signature Robert L. G. window M.D.

Date signed August 11 1943

Wolfe
G 07169
Lynette J.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 07169
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1706 Parker Court

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1706 Parker Court
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

male colored

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

12 hr. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name William Henry Edison

13. Birthplace Greenville, N.C.

14. Maiden Name Bertha Beatrice Woodard

15. Birthplace Winnsboro, S.C.

16 (a) Informant

(b) Address 1706 Parker Court

17 (a) Burial, cremation, or removal (b) Date thereof 8/14/48
(month) (day) (year)

(c) Cemetery or crematory location
Mt. Zion Cemetery
Chapel Hill, Md.

18 (a) Funeral director

(b) Address 927 N. Mount St

19 (a) Date of death 12-19-43 (b) Signature
Dr. Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1943, at 11 AM

21. I certify that death occurred on the date above stated; that I attended
deceased from 8/11 1943 to 8/12 1943,
and that I last saw him live on 8/12 1943.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature of Dr. Huntington Williams, D.

Address 1543 Remond Ave Date signed 8/14/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07170
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Worcester
(c) City or town Pocomoke City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

ANDREW McDOWELL

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ida Anderson

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 19, 1890

8. AGE: Years Months Days If less than one day

55

0

22

21

hr.

min.

9. Birthplace Oskaloosa, Iowa

(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Western Pines-6/41

12. Name Nathan McDowell

13. Birthplace Stanton, Va.

14. Maiden Name Georgia Harris

15. Birthplace Stanton, Va.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Removal (b) Date thereof 8-13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Pocomoke City

Location

18 (a) Funeral director Isaac L. Brown

(b) Address 108 W Montgomery St

19 (a) Address 108 W Montgomery St

VB 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Aug. 10, 1943, at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1943, to Aug. 10, 1943, and that I last saw him alive on Aug. 10, 1943.

Immediate cause of death.

Uremia

Duration

Unk.

Due to

Due to

Other Conditions Hypertensive cardio-vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/11/43

Va-13506

07171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07171
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1102 W. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County 1(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1102 W. Lexington St.

(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Mary Maggie Fisher

3 (b) If veteran, name war _____

3 (c) Social Security Account

No. none4. Sex F.5. Color or race Col.6 (a) Single, married, widowed, or divorced widow6 (b) Name of husband or wife James H. Fisher

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 10 - 18888. AGE: Years 65 Months 12 Days 2 If less than one day _____ hr. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Housework

11. Industry or business _____

12. Name Henry Horsey13. Birthplace Maryland14. Maiden Name Clementine B. Horsey15. Birthplace Maryland16 (a) Informant Louise Welles(b) Address 1102 W. Lexington St.17 (a) Burial (b) Date thereof Aug 15, 1943(c) Cemetery or crematory St. John'sLocation Highway Road18 (a) Funeral director St. John'sAddress Bridge - Mrs. Wanda M.19 (a) Aug 13, 1943 (b) Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1943 5:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16, 1942 to Aug 17, 1943and that I last saw her alive on Aug 9, 1943Cause of death Respiratory failureCoronary atherosclerosis

Due to _____

Other Cause Atherosclerosis

(Include pregnancy within 8 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? _____ While at work? _____

(Specify type of place)

(e) Means of injury U. S. Navy23. Signature W. F. HowellAddress 6017, Broadway AveDate 8/14/43

correct age is especially important.

07172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07172
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be stated clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1400 W. Lexington St

(c) Hospital or institution:

Aged Women's & Aged Men's Home

(d) Length of stay in hospital or inst. (yrs., mos., & days)

3 yrs

(e) Length of stay in Baltimore (yrs., mos., & days)

70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Balto

(d) Street No.

(If outside city or town limits, write RURAL and give town)

1400 W. Lexington St

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emma M. Kettle

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

about 1858

8. AGE: Years

Months

Days

If less than one day

about 85

hr.

min.

9. Birthplace

Helmsford Essex B. England

10. Usual Occupation

Female

11. Industry or business

Home for Aged

12. Name

James Kettle

13. Birthplace

England

14. Maiden name

Caroline Perry Richardson

15. Birthplace

England

16 (a) Informant

(b) Address

1400 W. Lexington St

17 (a)

Burial

(b) Date thereof

8/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ludon Park

Location

Balto Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19

Huntington Williams, MD

AUG 13 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 11th 1943 at 7 PM MD

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2/1930 to 8/11/1943

and that I last saw her alive on 8/10/43

Immediate cause of death

Carcinoma of the large bowel

(symptoms for 4 months)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thos B. Jones

Address 11 E. Chase St., City

Date signed 8/12/43

07173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07173
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2721 Ashland Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 Ashland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

GEORGE HYJOSTON STUART

3 (b) If veteran, name war

3 (c) Social Security Account
No. 216-03-9757

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Bertha Stuart

6 (c) If alive, give age YEARS

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE:

Years

Months

Days

If less than one day

59

1

6

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Pharmacist

11. Industry or business Drug

FATHER
MOTHER

12. Name Stuart

13. Birthplace Baltimore, Md.

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Bertha Stuart

(b) Address 2721 Ashland Ave.

17 (a)

Burial

(b) Date thereof

8/14/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Morland Park

Location

Parkville, Md.

18 (a) Funeral director

William Cook, Inc.

(b) Address

1217 St. Paul

AUG 13 1943

Washington Williams, M.D.

VR 181

MEDICAL CERTIFICATION

11:15 P.

20. DATE OF DEATH August 10, 1943, at M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.

23. Signature H. L. Wallenweller, M.D.

Medical Examiner.

Date signed 8-16-43

07174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07174

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 954 Forrest St.
 (c) Hospital or institution: Maryland Penitentiary
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2 30 12-4
 (e) Length of stay in Baltimore (yrs., mos., or days) ??

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 328-E 225 St.
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

John Lampkin
 3 (b) If veteran, name war No
 3 (c) Social Security Account No Did not remember

4. Sex Male 5. Color or race Black 6 (a) Single, married, widowed, or divorced Single
 6 (b) Name of husband or wife
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1923

8. AGE: Years 19 Months 10 Days 22 If less than one day min.

9. Birthplace South Carolina

10. Usual Occupation Hospital attendant

11. Industry or business

12. Name Joseph Lampkin

13. Birthplace Georgia

14. Maiden Name Mattie West

15. Birthplace Georgia

16 (a) Informant mother

16 (b) Address 328-E 225 St.

17 (a) (b) Date thereof 8-16-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County

18 (a) Funeral director J. J. Brown

(b) Address 1408 Ashland Ave

19 (a) Registrar Huntington Williams, M.D.

AUG 13 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943 12:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to Aug 13 1943, and that I last saw him alive on Aug 13 1943.

Immediate cause of death
 Dislocation of 5th cervical vertebra
 Due to Execution by hanging
 Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. F. Karns

Address 3614 Edmonston Ave Date signed 8-13-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be written clearly and legibly. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07175
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Green + Lombard*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

22 10 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 yrs

3 (a) FULL NAME

Ethel Louise Hicks

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

*Female Colored**Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 18-1940

8. AGE: Years

Months

Days

If less than one day

*3**2**24*

hr.

min.

9. Birthplace

Gastonia, N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

James Hicks

13. Birthplace

N.C.

14. Maiden Name

Eloise Walker

15. Birthplace

N.C.

16 (a) Informant

James Hicks

(b) Address

622 S. Hanover St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Aug 10-43

(c) Cemetery or crematory

Gastonia

Location

N.C.

18 (a) Funeral director

James A. Hayes

(b) Address

1424 N. 1st St

19 (a)

(Signature of Registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Bethesda

(If outside city or town limits, write RURAL and give town)

(d) Street No.

622 S. Hanover St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*8-12*19*43* at *12:30* P.M.21. I certify that death occurred on the date above stated; that I attended deceased from *8-11* 1943 to *8-12* 1943.and that I last saw her alive on *8-12* 1943.

Immediate cause of death

*Circulatory**collapse + heart failure*Due to *intestinal obstruction*Due to *Intussusception*

Other Conditions

Hemorrhoids

(Include pregnancy within 3 months of death)

Date of operation

8-11-43

Major findings of operation

Intussusception, Infected obstruction + hemorrhoids

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *W.R. Jenkins*Address *University Hosp* Date signed *8-12-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 13 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given in full and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07176
439079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07176
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA (b) County
(c) City or town Hazelton
(If outside city or town limits, write RURAL and give town)
Street No. 559 Seybert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Palumba
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife Joseph
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 10-26-03
8. AGE: Years 39 Months 9 Days 16 If less than one day hr. min.
9. Birthplace PA
(Town, county, and state)

10. Usual Occupation
11. Industry or business
12. Name Neil CRAIG
13. Birthplace Italy
14. Maiden Name ANNA MARIE GABRIEL
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug. 16, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Precious Blood Cemetery
Location Hazelton, Penna.

18 (a) Funeral director Andrew L. Tierro
(b) Address Hazelton, Penna.

19 (a) Aug. 16, 1943 (b) Huntington Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1943 1055 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1943 to Aug 12 1943, and that I last saw her alive on Aug 12 1943.

Immediate cause of death MYOCARDIAL FAILURE
Due to RHEUMATIC MYOCARDITIS
Due to RENAL FAILURE
Other Conditions MITRAL STENOSIS INSUFFICIENCY
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: None

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Gencin
Address Johns Hopkins Hospital Date signed 8-13-43

G 07177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX ✓ G 07177
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn (b) County(c) City or town Baltimore Waynesboro
(If outside city or town limits, write RURAL and give town)(d) Street No. 2 Pennsylvania Ave
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CHARLES

E

WOLFE

3 (b) If veteran, name war

3 (c) Social Security Account

No. 173-03-1504

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M.

6 (b) Name of husband or wife

Charlotte Helman

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

Aug 31, 1884

8. AGE:

Years

Months

Days

less than one day

58581111

hr.

min.

9. Birthplace

Waynesboro Pa.

(Town, county, and state)

10. Usual Occupation

Inspector

11. Industry or business

Fidelity Ship Co.

FATHER

12. Name

William Wolfe

13. Birthplace

Pa

MOTHER

14. Maiden Name

Leetitia Johnson

15. Birthplace

New St. Thomas Pa.

16 (a) Informant

Mrs Charlotte E Wolfe

(b) Address

Waynesboro Pa.

17 (a)

(Burial, cremation, or removal)

removal

(b) Date thereof

Aug. 13, 1943

(c) Cemetery or crematory

Green Hill

Location

Waynesboro Pa.

18 (a) Funeral director

Walter Y. Grove

(b) Address

27 S. Church St. Waynesboro Pa.

19 (a)

(Date of registration)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1943 at 1:30 M

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-12-43 7:45 29/6 M(b) Where did injury occur? Frankfort Ave nearfun H

(c) Did injury occur at home, on farm, industrial place, in public

place? public While at work?(d) Means of injury pedestrian struck by auto23. Signature W. A. Williams (M.D.)Date signed 8-12-43

correct age is especially important

VS 15

AUG 13 1943

G 07178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07178

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **2857 W. Lanvale St.,**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **2857 W. Lanvale St.,**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME **Clemence P. Sturm**

3 (b) If veteran, name war

3 (c) Social Security Account

No. **216-09-3709**4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or divorced
Married6 (b) Name of husband or wife **Gertrude Sturm**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 20, 1875**8. AGE: Years **68** Months **2** Days **22** If less than one day hr. min.9. Birthplace **Baltimore, Md.**
(Town, county, and state)10. Usual Occupation **Wood Finisher**11. Industry or business **Potthast Bros.**12. Name **Hubert Sturm**13. Birthplace **Germany**14. Maiden Name **Marie Hentschel**15. Birthplace **Germany**16 (a) Informant **Mrs. Gertrude Sturm**(b) Address **2857 W. Lanvale St.,**17 (a) **Burial** (b) Date thereof **Aug. 14, 1945**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Holy Redeemer**
Location **Belair Rd., Balto., Md.**18 (a) Funeral director **G. Howard Strong**
(b) Address **3207 W. North Ave.,**19 **Aug 13 1945** **Huntington Williams, M.D.**

MEDICAL CERTIFICATION

7.30

20. DATE OF DEATH **August 11, 1945** at **P.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 5 1945** to **Aug 11 1945** and that I last saw him alive on **Aug 11 1945**

Immediate cause of death

**Myocarditis
Chronic nephritis**

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Albert Scagnelli, M.D.**Address **1729 W. Lombard St.** Date signed **8/12/45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write name and address of physician.

G 07179
438926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07179

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Robert Block

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

Ida

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

3-25-88

8. AGE:

Years 55

Months 4

Days 18

If less than one day hr. min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

JAKE BLOCK

13. Birthplace

14. Maiden Name

Belle

15. Birthplace

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof 8-13-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Carmel

Location

German Hill Rd.

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1439 E. Balt St

19 AUG 18 1943 (h)

Huntington Williams M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1819 E. Chase

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1943 at 155 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Aug 13 1943 and that I last saw him alive on Aug 13 1943.

Immediate cause of death

Myocardial Failure

Duration

Due to Chronic hypertensive Cardiovascular disease

20 yrs

Due to ?

Other Conditions Pulmonary Edema (Post operative)

2 days

(Include pregnancy within 3 months of death)

Date of operation 8/11/43

Major findings of operations:

Benign Prostatic Hypertrophy

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. S. Skene

Address Johns Hopkins Date signed 8/12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every year or more, the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07180

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Address

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town line, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/12/

1943.

at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9/1943 to 8/12/1943 and that I last saw him alive on 8/12/1943

Immediate cause of death

urine

Duration

Due to

Renal insufficiency

Due to

Malignant nephrosclerosis
Malignant hypertension

Other Conditions

Hypertensive cardio-vascular disease
(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Linn Hospital

Date signed 8/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 806 S. Linwood Ave.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 806 S. Linwood Ave.
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

Sophia C. Winzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Paul F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1869

8. AGE:

Years

Months

Days

If less than one day

73711

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
MOTHER12. Name Frederich Hamm13. Birthplace Germany14. Maiden Name Rosa Rathgbi.15. Birthplace Germany16 (a) Informant Paul F. Winzer(b) Address 806 S. Linwood Ave17 (a) Burial (b) Date thereof 8/13/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Clarence F. Hoffmann(b) Address 1639 N. Broadway19 AUG 13 1943

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1943 19 at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1943 to Aug 10 1943, and that I last saw him alive on Aug 10 1943

Immediate cause of death

Carcinomatous

Duration

1943

Due to

Metastatic Bladder cancer

Due to

Other Conditions

(see)

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Walter G. LomanAddress 5013 Park Heights Ave Date signed 8-13-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07182

82445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07182
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 839 S. Conklin St.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

George Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Anna Brown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 8, 1868

8. AGE: Years

75

Months

4

Days

3

If less than one day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Pension

11. Industry or business

FATHER
MOTHER

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospital

(b) Address (Records)

17 (a) Burial (b) Date thereof 8/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) AUG 13 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11-1943

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6-1943 to 8-11-1943, and that I last saw him alive on 8-4-1943

Immediate cause of death

Hypertension

Direct

Pathological fracture

Direct

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Douglas B. Webb

Address Baltimore City Hosp. Date signed 8/11/43

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07183

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 33rd & Calvert Streets

(c) Hospital or institution:

Union Memorial Hospital 26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 123 South East Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mr. Wm. T. Karow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1888

8. AGE: Years Months Days If less than one day

55 4 18 17 hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Mr. George Roth

13. Birthplace Maryland

14. Maiden Name Margaret Shipley

15. Birthplace Maryland

16 (a) Informant Wm. T. Karow

(b) Address 123 S East Ave

17 (a) Burial (b) Date thereof 8/12/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave

18 (a) Funeral director Lawrence F. Hoffman

(b) Address 116 28 Broadway

19 (a) (b)

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1943 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1942 to 8-7 1942, and that I last saw her alive on 8-9 1942.

Immediate cause of death

Intestinal obstruction

Duration

2 yrs.

Due to Carcinoma of ovary, right & metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Nesbitt, Jr.

Address Union Memorial Hospital signed 8-7-43

M. D.

G 07184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07184

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Wilkins & Caton Ave.*

(c) Hospital or institution:

H. Agnew Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County(c) City or town *Balto* *Brooklyn*
(If outside city or town limits, write RURAL and give town)Street No. *3618 - 2nd St.*(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Isabelle Baumann

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

John G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 10, 1885

8. AGE: Years

Months

Days

If less than one day

*57**9**2*

hr.

min.

9. Birthplace

Balto.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John G. Baumann

13. Birthplace

Ind.

14. Maiden Name

Josephine Baumann

15. Birthplace

Ind.

16 (a) Informant

Family

(b) Address

3618 2nd St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof *8-14-43*

(c) Cemetery or crematory

Holy Cross

Location

Kitchin Highway

18 (a) Funeral director

Malton Schuchling

(b) Address

3900 Harmon St.

19 (a)

(b)

*Huntington Williams, M.D.**AUG 13 1943*

VB 114

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/12* 19*43* at *6:14*21. I certify that death occurred on the date above stated; that I attended deceased from *8/10* 19*43* to *8/12* 19*43*, and that I last saw him alive on *8/12* 19*43*.

Immediate cause of death

*Coronary Thrombosis*Due to *Coronary Thrombosis*
Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *V. J. Baumann*Address *H. Agnew Hosp* Date signed *8/12/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07185
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Catons + Wilkins Ave*

(c) Hospital or institution:

St Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*(e) Length of stay in Baltimore (yrs., mos., or days) *57 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *-*(c) City or town *Woodlawn, Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2113* *Gwynn Oak Ave*
(If rural give location)(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country *-*

3 (a) FULL NAME

*Florence R Willis*3 (b) If veteran, name war *-*3 (c) Social Security Account
No. *-*

4. Sex

Female

5. Color or race

*white*6 (a) Single, married, widowed, or
divorced. *married*

6 (b) Name of husband or wife

James A Willis(c) If alive, give age years *-*

7. Birth date of deceased (mo., day, yr.)

July 7, 1886

8. AGE: Years Months Days

57 1 34

If less than one day

hr. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER12. Name *John Childs*13. Birthplace *Unknown*14. Maiden Name *Maude Childs*15. Birthplace *Md.*16 (a) Informant *Mr. Jas. A. Willis*(b) Address *2113 Gwynn Oak Ave*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *8/14/43*

(month) (day) (year)

(c) Cemetery or crematory *Woodlawn Cem.*Location *Woodlawn Md.*18 (a) Funeral director *WM. J. TICKNER & SONS INC*(b) Address *North & Pa Aves.*19 (a) *AUG 13 1943*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/11/43* at *11 PM*21. I certify that death occurred on the date above stated, that I attended
deceased from *8/9 1943* to *8/11 1943*,
and that I last saw him alive on *8/11 1943*.Immediate cause of death *Appendiceal
abscess and generalized
peritonitis*
Due to *Perforated appendix*Due to *-*Other Conditions *Cardio respiratory
failure*

(Include pregnancy within 3 months of death)

Date of operation *8/11/43*Major findings of operations *Ruptured
gangrenous appendix, abscess*
of autopsy *not done*

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *-* at *M*(c) Where did injury occur? *-*
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? *-* While at work?
(Specify type of place)(e) Means of injury *-*23. Signature *Howard W. Stein*Address *St Agnes Hospital* Date signed *8/11/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07186

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information shown on this form is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 2826 Walbrook Ave
- (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2826 Walbrook Ave
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FLORENCE M. RAUSCH

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Frederick A. Rausch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 2, 1872

8. AGE: Years Months Days If less than one day
70 8 9 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John H. Thiemeyer

13. Birthplace Germany

14. Maiden Name Cecelia Meyers

15. Birthplace Germany

16 (a) Informant Mr. Frederick H. Rausch

(b) Address 4411 Harcourt Road

17 (a) Burial (b) Date thereof 8/14/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.

(b) Address 1000 N. E. Ave. Balto. Md.

19 (a) (b)
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1943, at 12:35 A

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942, to Aug 11, 1943, and that I last saw her alive on Aug 9, 1943

Immediate cause of death

Coronary Thrombosis
Due to Anterior Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
- (e) Means of injury
- Signature M. J. Tickner
- Address 4710 Liberty Hts Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

G 07187

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1342 Whatcoat St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *15*

(e) Length of stay in Baltimore (yrs., mos., or days) *17 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1342 Whatcoat St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Eliza Ball

3 (b) If veteran, name war

3 (c) Social Security Account

No. *215-18-3046*

4. Sex

Female

5. Color or race

A.A.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

John Ball

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/5/72

8. AGE:

Years

Months

Days

If less than one day

71

-

6

7

hr.

min.

9. Birthplace

Fauquier Co., Virginia

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

12. Name

Benjamin Stewart

13. Birthplace

Fauquier Co., Va

14. Maiden Name

Eliza

15. Birthplace

Fauquier Co., Va

16 (a) Informant

Mrs Clara Henderson

(b) Address

4 Terrace St. Phil. Pa

17 (a) *Burial*

(b) Date thereof

Aug 14 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

Brooklyn

18 (a) Funeral director

Brooks

(b) Address

1463 N. Carey St

19 (a)

(Date rec'd by registrar)

Aug 13 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/14 1943 at 8 P M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *8/8 1943* to *8/11 1943*

and that I last saw him alive on *8/11 1943*

Immediate cause of death

Mysocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Carson C. Johnson

Address

1802 Penna Ave

Date signed *8/14/43*

Duration

2 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

SM
G 07188
82216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07188
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
LMO. 20 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Marshall St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

William Brisbois

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-03-2730

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Bonnie Brisbois

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1892

8. AGE: Years

51

Months

4

Days

14

If less than one day

hr.

min.

9. Birthplace

Michigan

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

Hendry's Cream Co.

FATHER

12. Name Charles Brisbois

13. Birthplace Canada

MOTHER

14. Maiden Name Annie Bertrand

15. Birthplace Canada

16 (a) Informant Baltimore City Hospital

(b) Address (Records)

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 14, 1943
(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill Cr.

Location

G. G. Co. Ind.

18 (a) Funeral director

G. Howard Evans

(b) Address

1400-02 S. Charles St.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1943 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 6-22-1943 to 8-11-1943.
and that I last saw him alive on 8-11-1943.

Immediate cause of death

Generalized Peritonitis

Due to

Intestinal Obstruction

Other Conditions

Bilateral Emphysema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-11-43

Major findings of operations: None

of autopsy:

Duration

2 hrs

?

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Donald B. Hart

Address

Baltimore City

Date signed

8-11-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully
checked and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07189
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MONUMENT ST.

(c) Hospital or institution:

SINIA HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY

(e) Length of stay in Baltimore (yrs., mos., or days) 7 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 8 E. EAGER ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

June Giboney

3 (b) If veteran, name

NO

3 (c) Social Security Account

No.

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife FRANK GIBONEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 22 1915

8. AGE: Years Months Days If less than one day
28 10 21 20 hr. min.

9. Birthplace DAYTON OHIO

(Town, county, and state)

10. Usual Occupation TELEPHONE OPR.

11. Industry or business C & P TELEPHONE CO.

12. Name HARRY CASHNER

13. Birthplace OHIO

14. Maiden Name FLETA JOLLAY

15. Birthplace OHIO

16 (a) Informant HARRY CASHNER (FATHER)

(b) Address 8 E. EAGER ST.

17 (a) BURIAL (b) Date thereof AUG. 16/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory STILL WATER

Location WEST MILTON OHIO

18 (a) Funeral director Lillard & Geiler INC

(b) Address 403 S. WOLFE ST.

19 (a) AUG 12 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1943, 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1943, to 8/11 1943, and that I last saw him alive on 8/11 1943.

Immediate cause of death

Pulm. Edema

Due to Arterio Sclerosis, Atherosclerosis, unknown

Due to

Other Conditions Pneumonia, 1st pregnancy
(Include pregnancy within months of death)

Date of operation

Major findings of operations

of autopsy: Pulm. Edema

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raymond B. Healy

Address Sinia Hosp. Date signed 8/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07190
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2323 McElderry St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Robert E. Garcia

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 218 03 2097

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife RUTH GARCIA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 9 1903

8. Age

Years

Months

Days

If less than one day

40

5

2

hr.

min.

9. Birthplace ELPASO TEXAS

(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
MOTHER

12. Name ROBERT GARCIA

13. Birthplace TEXAS

14. Maiden Name UNKNOWN

15. Birthplace TEXAS

16 (a) Informant RUTH GARCIA (WIFE)

(b) Address 2323 McELDERRY ST.

17 (a) BURIAL (b) Date thereof AUG. 16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory US. NATIONAL

Location FREDERICK AVE.

18 (a) Funeral director Lilly and Geisler INC.

(b) Address 403 S. WOLFE ST.

19 (a) AUG 19 1943

(Date of death)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1943, at 10 25 P.M.

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury August 11 1943 1 P.M.

(b) Where did injury occur? 200 block of Kramon St.

(c) Did injury occur at home, on farm, industrial place, in public

place? public While at work? yes

(d) Means of injury Caught between 2 freight cars

23. Signature Robert E. Garcia M.D.

Date signed August 12 1943

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Eckenside 07191
Registered No. 124 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3904 Old Fresh Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

Harvey Co

(c) City or town

Hayes town
(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Margaret R Eckenside

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-10-7517

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 13 / 1881

8. AGE:

Years

Months

Days

If less than one day

61

62

11

29

hr.

min.

9. Birthplace

Mayland

(Town, county, and state)

10. Usual Occupation

Club RR

11. Industry or business

W M RR

12. Name

Fred M Eckenside

13. Birthplace

MD

14. Maiden Name

May E Logue

15. Birthplace

Mayland

16 (a) Informant

Miss Anna M Eckenside

(b) Address

3904 Old Fresh Rd

17 (a)

Funeral

(b) Date thereof

8-14-43

(c) Cemetery or crematory

Location

Catholic

18 (a) Funeral director

Funeral & Fair

(b) Address

Funeral & Fair

19 (a)

8/13/43

(b)

(Date recd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/11

19

43 at 5:15

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Aug 1943

and that I last saw him on July 11 1943

Immediate cause of death

Left cerebral thrombosis

Duration

1 day

Due to

Due to

Other Conditions

Hypertensive

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

D. P. Hayes

Address

33 W. 7th St.

Date signed

8/14/43

G 07192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07192

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3550 Chesterfield Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State 2nd (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3550 Chesterfield Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Paul J. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Carrie Raftery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11/19/1908

8. AGE:

Years

Months

Days

If less than one day

34

8

22

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Lumberman for

11. Industry or business

City of Baltimore

FATHER

12. Name

James Stewart

13. Birthplace

Md

MOTHER

14. Maiden Name

Mattie Rawan

15. Birthplace

Md

16 (a) Informant

Mrs. P. J. Stewart

(b) Address

3550 Chesterfield Ave

17 (a)

Burial

(b) Date thereof

8/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Catharine

Location

1802 Eastern Ave

18 (a) Funeral director

B. J. Light

(b) Address

1802 Eastern Ave

19 (a)

(b)

AUG. 13 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1943 1:20 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943 to Aug. 12 1943, and that I last saw him alive on Aug. 11 1943.

Immediate cause of death Acute Cardiac Dilatation

Due to Ischemic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John V. Szymanski

Address

1802 Eastern Ave

Date signed 8-13-43

Duration

1 day

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 07193
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Murray Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1811

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

611 St Paul St

(e) Citizen of foreign country

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

John M. O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 27 1886

8. AGE: Years

57

Months

Days

17

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Organist

11. Industry or business

12. Name

John O'Connor

13. Birthplace

Baltimore Md. Ireland

14. Maiden Name

Anne McGuire

15. Birthplace

Baltimore Md. Ireland

16 (a) Informant

Murray Hosp. Record

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 14 43

(c) Cemetery or crematory

New Cathedral

Location

Baltimore Md

18 (a) Funeral director

John J. McKinnis, Inc.

(b) Address

M. C. Culbertson, Inc.

AUG 13 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 12 1943 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1943 to Aug 12 1943 and that I last saw him alive on Aug 12 1943.

Immediate cause of death

Pneumonia

Duration

4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations

or autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

J. Carlton Wish

Address

Murray Hosp.

Date signed

M. D.

8-12-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 07194
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 221 E. Biddle St.(c) Hospital or institution: —(d) Length of stay in hospital or inst. (yrs., mos., or days) 11(e) Length of stay in Baltimore (yrs., mos., or days) Since 1917

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County —(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 221 E. Biddle St.
(If rural give location)(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME

Anna Merryman Carroll3 (b) If veteran, name war —3 (c) Social Security Account
No. —

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Married6 (b) Name of husband or wife Henry Carroll6 (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) Nov. 18, 18788. AGE: Years 64 Months 8 Days 25 hr. 24 min. —
If less than one day9. Birthplace Georgia
(Town, county, and state)10. Usual Occupation Housewife11. Industry or business At Home12. Name N. Bosley Merryman13. Birthplace Cockersville, Md.14. Maiden Name Wilmington N. McClesky15. Birthplace Georgia16 (a) Informant Henry Carroll(b) Address 221 E. Biddle St., Balto., Md.17 (a) Burial (b) Date thereof Aug 14, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Immortal Cemetery
Location Glencoe, Balto. Co., Md.18 (a) Funeral director Henry N. Williamson Co.(b) Address Chesapeake Mall, Baltimore, Md.19 (a) — (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1943 11:15 A.M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 1942 to Aug. 12, 1943,
and that I last saw him alive on Aug. 12, 1943.

Immediate cause of death

Chronic nephritis
Uremia

Duration

15 yrs?
2 mosDue to —Due to —Other Conditions Cardiac hyper-
trophy
(Include pregnancy within 3 months of death)Date of operation —Major findings of operation: —of autopsy: —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —(b) Date of occurrence — at — M(c) Where did injury occur? —
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? — While at work? —
(Specify type of place)(e) Means of injury —23. Signature M. H. H. H.Address 1041 St. Paul St Date signed 8/12/43 M. D.

VS 1 AUG 13 1943

G 07195

G 07195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Bolton St. 11-4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 11 mos. 4 da. How long in U. S. If of foreign birth? yrs. 11 mos. 4 da.2. FULL NAME Fannie E Goldstorough

If U. S. Veteran

specify WAR

(a) Residence: No. 1309 Bolton St

(Usual place of abode)

St. 11-4 Ward.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color, or Race White 5. Single, Married, Widowed, or Divorced (write the word) Widowed6a. If married, widowed, or divorced, Widowed (or) WIFE of Matthew Telegrapher Goldstoroughc. DATE OF BIRTH (month, day, year) Sept 14, 18717. AGE Years 71 Months 10 Days 29 If LESS than 1 day, hrs. 25 For min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None10. Date deceased last worked at this occupation, (month and year) 1941 11. Total time (years) spent in this occupation12. BIRTHPLACE (city or town) Easton (State or country) Maryland13. NAME Francis H. Johnston14. BIRTHPLACE (city or town) Easton (State or country) Maryland15. MAIDEN NAME Anna Goldstorough16. BIRTHPLACE (city or town) Easton (State or country) Maryland17. INFORMANT Mrs. Frances Goldstorough (Address) 1309 Bolton St

18. BURIAL, CREMATION, OR REMOVAL

Place Easton Md Date Aug 14, 194219. UNDERTAKER Henry M. Jenkins - Sons (Address) McClure & Orchard Sts.20. FILED Aug 13 1942 19 1942

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 12, 194322. I HEREBY CERTIFY, That I attended deceased from November 1941 to August 22 1943. Last saw her alive on August 11 1943. Death is said to have occurred on the date stated above, at 8:25 A. M.

The principal cause of death and related causes of importance were as follows:

arteriosclerosis
Chronic Myocarditis

Date of onset

19411941

Other contributory causes of importance

noneWas an operation performed? none Date ofFor what disease or injury? —Name of operation — Date ofWhat test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury 19Where did injury occur? —

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —Manner of injury —Nature of injury —24. Was disease or injury in any way related to occupation of deceased? —

If so, specify

(Signed)

(Address)

Francis M. Gluck
215 Park Ave

M. D.

OCCUPATION is very important. See instructions on back of certificate.

G 07196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07196

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 819 N. Washington Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 819 N. Washington St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY REYNOLDS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife THOS. REYNOLDS

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) JAN. 13 - 1873

8. AGE: Years Months Days If less than one day
70 6 28 hr. min.9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

12. Name PETER P. CRIGHAN

13. Birthplace IRELAND

14. Maiden Name ELIZABETH O'CONNOR

15. Birthplace IRELAND

16 (a) Informant VERONIE KLIMM

(b) Address 819 N. WASHINGTON ST

17 (a) BURIAL (b) Date thereof 8/14/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ST. VINCENT'S

Location

18 (a) Funeral Home J. Evans & Son

(b) Address 118 N. Mt. Royal Ave

19 (a) AUG 13 1943 (b) Registrar
W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1943, at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. H. Wallenbergh M.D.

Date signed 8-11-43

G 07197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07197

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1250 S Sharp St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

14 9 20 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof Aug 17, 1943

(month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location

18 (a) Funeral director

(b) Address

19 (a) August 13, 194319 (b) Thurston Williams

(Registrar)

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1943, at 10 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1943, to Aug. 13, 1943, and that I last saw her alive on Aug. 13, 1943.Immediate cause of death Tetanus

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1213 Light St. Date signed 8/13/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07198

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 13, 1943, at 10 A. M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Date signed

H. J. Wallenmeyer M.D.
Medical Examiner.

8-13-43

06 07199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07199

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 3605 Hillside Road.

(c) Hospital or institution:

Anderson Nursing Home.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3605 Hillside Road.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

CLARA EHRLICH

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1857.

8. AGE: Years Months Days

86

1

6

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name Alexander Ehrlich,

13. Birthplace

Germany.

14. Maiden Name Fannie Hamburger,

15. Birthplace

Germany.

16 (a) Informant Mrs. Leon Mayer,

(b) Address Belvedere Hotel.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/15/43.

(month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director David Souders

(b) Address 1902 Rutaw Place.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12th. 1943, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1941, to Aug 12, 1943 and that I last saw her alive on Aug. 11, 43.

Immediate cause of death

Myocarditis

Pulmonary Edema

Due to

Arterio Sclerosis

Due to

Hypertension

Other Conditions

Diabetes Mellitus 3 yrs.

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Theodore H. Morrison

Address 11 E. Chase St.

Date signed

M. D.

correct age is especially important. Physicians: please write the true date.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07200

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. Hopkins Apt. St Paul & 31st St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) FULL NAME

Miss Ella Mary Miller
(b) If veteran, name war
(c) Social Security Account No.

4. Sex 7 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1863
8. AGE: Years 79 Months 9 10 Days 10 If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired Registered nurse

11. Industry or business

12. Name Jacob P. Miller
13. Birthplace Penna

14. Maiden Name Jamima Shoemaker
15. Birthplace Penna

16. (a) Informant Mrs. C. Warren Black
(b) Address 329 Tumbidge Road

17. (a) Burial (b) Date thereof August 15, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Newville, Pennsylvania

18. (a) Funeral director Ellsworth Armistead
(b) Address 3911 Liberty Heights Ave.

19. Date rec'd by registrar AUG 13 1943
20. Signature of registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12, 1943, at 7:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 24, 1943, to Aug 12, 1943, and that I last saw him alive on Aug 12, 1943.

Immediate cause of death Cardiorespiratory failure

Due to Cerebral Vase Accident

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature Francis W. Miller M.D.

Address Date signed

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07201

CERTIFICATE OF DEATH

131 B G 07201

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 W. Fayette St., 2 Ward)

Length of residence in city or town where death occurred: 53 yrs. 5 mos. 7 da. How long in U. S. If of foreign birth? 53 yrs. 5 mos. 7 da.

2. FULL NAME

Russie Saunders

(a) Residence: No. 1030 W. Fayette St., 2 Ward.

(Usual place of abode)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

If U. S. Veteran specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race Colored 5. Single, Married, Widowed, or Divorced Widowed

6a. If married, widowed, or divorced HUSBAND of Columbus Saunders (or) WIFE of

6. DATE OF BIRTH (month, day, year) March 4, 1890

7. AGE Years 53 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

13. NAME Frank & Elmer

14. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

15. MAIDEN NAME Rachel Queen

16. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

17. INFORMANT Sarah Joy (Address) 812 W. Lexington St.

18. BURIAL CREMATION, OR REMOVAL Place Mt. Auburn Date 8-14 1943

19. UNDERTAKER Mrs. Katie R. Williams (Address) 229 S. Schenck St.

20. FILED 14 Thurston Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 11 1943

22. I HEREBY CERTIFY, That I attended deceased from 4-26-1943 to 8-11-1943

I last saw him alive on 8-10-1943 Death is said to have occurred on the date stated above, at 8:15 a.m.

The principal cause of death and related causes of importance were as follows:

Cardio vascular disease

Date of onset 3/4/40

Other contributory causes of importance:

Nephritis

6 mos.

Was an operation performed? no Date of —

For what disease or injury?

Name of operation physical signs & symptoms

What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury —

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify

(Signed) John E. J. Campbell

(Address) 639 N. Carey St., Balto.

state CAUSE OF DEATH in plain terms, as far as may be possible. See instructions on back of certificate. OCCUPATION is very important.

10181

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07202

CERTIFICATE OF DEATH

131 B

G 07202

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 768 George St., 3 Ward)

Length of residence in city or town where death occurred yrs. 17 mos. 3 da. How long in S. If of foreign birth? yrs. 17 mos. 3 da.

2. FULL NAME

(a) Residence: No. 768 George St., 3 Ward.

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U.S. Veteran specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race C. of 5. Single, Married, Widowed, or Divorced (write the word) Widowed

6a. If married, widowed, or divorced HUSBAND of Belaine K. Kootz (or) WIFE of

6. DATE OF BIRTH (month, day, year) Dec. 25, 1888

7. AGE Years 54 Months 7 Days 15 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Staunton (State or country) Va.

12. NAME Nathan Williams
14. BIRTHPLACE (city or town) Staunton, Va (State or country)

15. MAIDEN NAME Mary
16. BIRTHPLACE (city or town) Staunton (State or country) Va.

17. INFORMANT Miss Jennie Taylor (Address)

18. BURIAL, CREMATION, OR REMOVAL St. Auburn Date Aug 13, 1943

19. UNDERTAKER Mrs. Kate R. Williams (Address) 322 N. Schaefer St.

20. SIGNATURE Frank E. Wagner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 10, 1943

22. I HEREBY CERTIFY, That I attended deceased from June 20, 1943 to Aug 10, 1943

I last saw him alive on Aug 9, 1943 to have occurred on the date stated above, at 7:50 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic
nephritis

Other contributory causes of importance:

Was an operation performed? _____ Date of _____

For what disease or injury?

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? _____ If so specify _____

(Signed) Frank E. Wagner M.D.

(Address) 3027 Calvert

Frank E. WIRGNER

state CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

G 07203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 07203

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~State~~ *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *657 W. Bane St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROSELAND CUNNINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

2 *42* *10* hr. min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 12* 19*43* at *8:30* M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature *H. J. Wallenmeyer* M.D.Date signed *8-13-43*

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07204
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel
 (c) City or town Severna Park
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. Odenton Road
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

CONRAD DISCHOFF

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Cecelia Spangenberg6 (c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) Jan. 1, 18768. AGE: Years Months Days If less than one day
67 7 712 hr. min.9. Birthplace New Jersey
(Town, county, and state)10. Usual Occupation Pharmacist

11. Industry or business

12. Name Joseph Dischoff13. Birthplace France14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Cecelia Dischoff(b) Address Parkton, Md.17 (a) Burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer Cem.Location Balto. Md.18 (a) Funeral director Howard S. Goshlin(b) Address White Oak, Md.19 AUG 13 1943 Walter Williams, M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

9:45 A.

20. DATE OF DEATH August 13, 1943 at M

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
 Autopsy, Inspection or Inquiry
 by said Autopsy, Inspection or Inquiry, find that said deceased came
 to his death on the day stated above, and death in my
 opinion resulted from: natural causes ☒ accident ☐ suicide ☐
 homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Williams, M.D.Date signed 8-13-43

Medical Examiner.

G 07205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9326

07205

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4702 Harford Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1520 Halbrook St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Fannie Kinnear

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

widow

6 (b) Name of husband or wife Andrew Kinnear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1851

8. AGE: Years Months Days If less than one day
92 7 10 hr. min.9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Thomas Thompson

13. Birthplace Ireland

14. Maiden Name Davis

15. Birthplace Ireland

16 (a) Informant Elizabeth M. - Donald

(b) Address 2962 Poplar St. E. R.

17 (a) Burial (b) Date thereof 8-14-43
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md.

18 (a) Funeral director Duxward D. Corington

(b) Address 21 W. 20th St.

19 (a) (b)

(Date rec'd by)

AUG 13 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1943 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943, to Aug 10 1943, and that I last saw her alive on Aug 10 1943

Immediate cause of death

Acute myocarditis

Duration

4 wks

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H.V. Harold M.D.

Address 4706 Harford Road Date signed 8/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07206
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2516 W. Lafayette Ave
(c) Hospital or institution: _____

(d) Length of stay in hospital or inst. (yrs., mos., or days) _____

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) Baltimore (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME Marcellus Stephens

3 (b) If veteran, name war no

3 (c) Social Security Account
No. 214-01-6516

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Annie S. Stephens

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 2 - 1879

8. AGE: Years 64 Months 2 Days 9 If less than one day
_____ hr. _____ min.

9. Birthplace Middleton Maryland
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business McConnick & Co.

FATHER 12. Name Winfield S. Stephens

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Amanda S. Easterday

15. Birthplace Frederick Co. Md.

16 (a) Informant Annie S. Stephens

(b) Address 2516 W. Lafayette Ave.

17 (a) Burial (b) Date thereof Aug 14-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Beltinport Md.

18 (a) Funeral director F. B. Muffett, Inc.

(b) Address 1300 Euterpe Place

Huntington Williams, Md.

(Date for use by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 - 1943 at 1:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 - 1943 to August 11 - 1943, and that I last saw him alive on August 10 1943.

Immediate cause of death

Influenzal Encephalitis

Duration

11 days

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation _____

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Chas. P.iland

Address 2532 Edmondson Ave Date signed 8-11-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07208
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *University Hospital*
(c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days) *13 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *-*

3 (a) FULL NAME

- James Edward Duckett*
3 (b) If veteran, name war *None* 3 (c) Social Security Account No. *215-18-9797*

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced.

- 6 (b) Name of husband or wife *Virginia* 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 1901*

8. AGE: Years *42* Months Days If less than one day hr. min.

9. Birthplace *Md.* (Town, county, and state)

10. Usual Occupation *Farmer*

11. Industry or business

12. Name *Frank Duckett*

13. Birthplace *Md.*

14. Maiden Name *L. Duckett*

15. Birthplace *Md.*

- 16 (a) Informant *Virginia Duckett*

- (b) Address *Davidsonville, Md.*

- 17 (a) *Burial* (b) Date thereof *Aug 16/43* (month) (day) (year)

- (c) Cemetery or crematory *Davidsonville*

- Location *Davidsonville, Md.*

- 18 (a) Funeral director *B. L. Hopkins*

- (b) Address *Annapolis, Md.*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *Anne Arundel*
(c) City or town *Davidsonville* (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 12 1943* at *7:00 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *July 30 1943* to *Aug 12 1943* and that I last saw him alive on *Aug 12 1943*

- Immediate cause of death *Brain abscess*

- Due to *Chronic empyema*

- Due to *Pneumonia*

- Other Conditions *Injury of base*

- (Include pregnancy within 3 months of death)
Date of operation

- Major findings of operations:

- of autopsy: *Brain abscess*

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

- (e) Means of injury *Gun*

23. Signature *G. K. Ruzicka, Jr.* M. D.
Address *University Hosp* Date signed *8/13/43*

Duration
5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 13 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07210
419534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07210
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Robert B Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-38

8. AGE: Years 5 Months 2 Days 5 If less than one day hr. min.

9. Birthplace

VA
(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

12. Name Dewitt Martin

13. Birthplace

VA

14. Maiden Name Leona Bailey

15. Birthplace

VA

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 13 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 13 1943

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County ANN ARUNDEL

(c) City or town

ANNE ARUNDEL ODETION
(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1943 at 1255 A

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1942 to Aug 13 1943 and that I last saw him alive on Aug 13 1943.

Immediate cause of death

paralysis

Due to progressive degeneration

of C.N.S.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-22-42

Major findings of operations: Absence of

spinal cord

of autopsy: 8-13-43

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Henry Bowie

Address Johns Hopkins Hosp.

Date signed Aug 13 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07211

Registered No.

50

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 564 W. University Parkway
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 564 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME Georgie P. McCrea

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Lester W. McCrea
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1893

8. AGE: Years 49 Months 10 Days 30 29 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name George Preston
13. Birthplace Baltimore, Md.

14. Maiden Name Margaret L. Schumacher
15. Birthplace Baltimore, Md.

16 (a) Informant Lester W. McCrea
(b) Address 564 W. University Parkway

17 (a) Burial (b) Date thereof 8/14/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19. Registrar
20. Date of death 8-13-1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 43 at 8.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1936 to Aug 12 1943.
and that I last saw her alive on Aug 12 43

Immediate cause of death

Carcinoma Breast
Bilateral

Duration

7 yrs

Due to

Due to

Other Conditions

(Include procedure within 3 months of death)
Date of operation 8/22/36, 7/4/43
Major findings of operation: Carcinoma
metastases to axilla & bone
of autopsy: None obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Grant E. Ward
Address Medical Arts Bldg. Date signed 8/13/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Gross

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1916

8. AGE: Years 26 Months 9 Days 26 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Race Track

11. Industry or business

12. Name Louis Gross

13. Birthplace Md

14. Maiden Name Melvina Smith

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern

17 (a) Burial (b) Date thereof Aug 19 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Brewer Hill
Location Annapolis

18 (a) Funeral director B. Johnson

19 (a) AUG 14 1943

(b) Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1943, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-P 1943 to 8-12 1943 and that I last saw him alive on 8-12 1943.

Immediate cause of death Hypertension & coron artery unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: no help, brain

of autopsy: How nothing

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul H. H. M.D.

Address B.C.H. Date signed 8/12/43

Duration 10 days
PHYSICIAN Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07213

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution:

Union Memorial Hospital, 21-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1124 S. Burgundy St.

(If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME

Roland Joseph Le Blanc

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

6 10 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Gilbert Arthur Le Blanc

13. Birthplace Maryland

14. Maiden Name Ruth Smith

15. Birthplace Canada

16 (a) Informant Hospital Records.

(b) Address

17 (a) Burial (b) Date thereof Aug. 14-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director William Corp Inc.

(b) Address 1217 20th St.

19 AUG 14 1943

(Date of death) Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1943, 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1943, to Aug. 13, 1943, and that I last saw him alive on Aug. 13, 1943.

Immediate cause of death

Cardio-respiratory arrest

Due to Broncho-pneumonia

Due to Left upper lobe

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Presbitt, Jr. M.D.

Address 33rd & Calvert Date signed 8/13/43

Duration

Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

07214

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1565 Homestead St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943. at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10, 1943, to Aug 13, 1943, and that I last saw her alive on Aug 12, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6-07215

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Nancy Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

Sept. 24, 1942

8. AGE:

Years

Months

Days

10 12 2 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Melvin Kelly

13. Birthplace

Baltimore

14. Name

Marion M. Smith

15. Birthplace

Baltimore

16 (a) Informant

Miss Eleanor Smith

(b) Address

1122 Burgundy St.

17 (a)

(Burial, cremation, or removal)

Burial

(c) Cemetery or crematory

London

Location

Baltimore

18 (a) Funeral director

Wm. B. Book Inc.

(b) Address

1001 N. Pratt St.

19 (a)

(Date rec'd by registrar)

August 14, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1943, at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6, 1943, to Aug. 13, 1943, and that I last saw her alive on Aug. 13, 1943.

Immediate cause of death Acute gastro-
enteritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at PM

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul H. Lukats

Address 1213 Light St. Date signed 8/13/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07216
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 85 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 11 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 715 Gold St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Elizabeth Nelson

81556

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

black

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1907

8. AGE: Years Months Days If less than one day

36

0

7

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

William Brown

13. Birthplace

Va.

14. Maiden Name

Annie Abrams

15. Birthplace

Md.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 13, 1943

(month) (day) (year)

(c) Cemetery or crematory

Location

Arbutus Mem. Park
Baltimore Co. Md.

18 (a) Funeral director

(b) Address

Mr. George W. Holland
1631 Druid Hill Ave.

19 AUG 14 1943 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1943 9:35A M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from May 18 1943 to Aug. 11 1943.
and that I last saw h. or alive on Aug. 11 1943.

Immediate cause of death

Pulmonary tuberculosis

Duration

4 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul Mattman

Address

B. O. H.

Date signed

8/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07217

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Dinsin St.

(c) Hospital or institution:

Proident Hospital 14-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1928 Madison Ave

(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Willie Liggett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

42

hr.

min.

9. Birthplace

Crookland, Va.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name Timothy Hudson

13. Birthplace Virginia

14. Maiden Name Henrietta Burkley

15. Birthplace Virginia

16 (a) Informant James T. Dudley

(b) Address 1309 Union St. N.W. Wash. D.C.

17 (a) Burial

(b) Date thereof Aug. 14, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Richmond, Va.

18 (a) Funeral director Mrs. George W. Holland

(b) Address 1631 Daniel Hill Ave.

19 (a) AUG 14 1943

(Date of death)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1943 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1943, to Aug 11 1943, and that I last saw her alive on Aug 11 1943

Immediate cause of death

Cirrhosis of the liver

Due to

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. G. Campbell

Address Proident Hospital Date signed 8-11-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07218

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 716 W. Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore(d) Street No. 716 W. Lafayette Ave (If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (If rural give location)

(f) If yes, name country (Yes or No)

3 (a) FULL NAME

PerryTolson

3 (b) If veteran, name was

(c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1873

8. AGE: Years Months Days If less than one day

7023

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Ins. Agent

11. Industry or business

12. Name Perry S. Tolson13. Birthplace Md.14. Maiden Name Not Known

15. Birthplace " "

16 (a) Informant John E. Tolson(b) Address 716 W. Lafayette Ave.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8-17-43

(month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.Location Baltimore, Md.18 (a) Funeral director Mrs Frances A. Hemaley(b) Address 578 W. Biddle St.

AUG 14 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943 at 12 20 P M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Arteriosclerosiscardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature Robert E. Graham M.D.Date signed Aug 13 1943 Medical Examiner

correct age is especially important. Physicians, please print name and address.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

434907
G 07219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07219

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1610 N. Bradford
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Jimenez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female White

Married

6 (b) Name of husband or wife

Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1907

8. AGE:

Years

Months

Days

If less than one day

36

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Wm. H. Magliet

13. Birthplace

Md.

MOTHER

14. Maiden Name

Doxgen

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof 8-14th 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Moreland

Location

Taylor Ave

18 (a) Funeral director

Les S. Brook

(b) Address

1701-03 N. Pratt Park Ave.

19

AUG 14 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1943 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1943 to Aug 11 1943, and that I last saw her alive on Aug 11 1943.

Immediate cause of death

Chronic Myeloid Leukemia

Duration

7 yrs.

Due to

Chronic myeloid leukemia

7 yrs

Due to

Other Conditions ? Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert Day

Address

Johns Hopkins Hosp

Date signed 8/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07220

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1104 Peach St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

45

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1104 Peach Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Rebecca Thomas

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

W

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Oct 1864

8. AGE:

Years

Months

Days

If less than one day

78

10

hr.

min.

9. Birthplace

a a c m d

(Town, county, and state)

10. Usual Occupation

domestic

11. Industry or business

FATHER

12. Name

Lloyd Harris

MOTHER

13. Birthplace

Md

14. Maiden Name

Sarah Grayson

15. Birthplace

Md

16 (a) Informant

Thomas J. Harris

(b) Address

711 Bruce St

17 (a)

Burial

(b) Date thereof

8-14-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

a a c m d

18 (a) Funeral director

Isaiah I Brown

(b) Address

109 W Montgomery St

19 (a)

Aug 14 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 10, 1943, 7⁴⁰ P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1943 to Aug 10 1943 and that I last saw her alive on Aug 10 1943

Immediate cause of death

Chr. Cardio-renal disease

Due to

Senile Changes

Due to

Other Conditions

Senile Changes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John W. Harris

Address

665 W. Baw St

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is especially important. Physicians: please write the causes of death clearly and legibly.

07221

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07221
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caroline & Oliver Sts*

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1/2 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County *Baltimore*

(c) City or town *Bel Air, Perry Hall*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *Schroeder Ave.*

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr. Frank Eisner

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. *none*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife *Minnie C. Eisner*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 1st 1893*

8. AGE:

Years *49* Months *11* Days *11* If less than one day

9. Birthplace *Baltimore Co. Maryland*

(Town, county, and state)

10. Usual Occupation *Florist*

11. Industry or business

12. Name *August Eisner*

13. Birthplace *Baltimore*

14. Maiden Name *Elizabeth Schuratzky*

15. Birthplace *Unknown*

16 (a) Informant *Mrs. Minnie C. Eisner*

(b) Address *Schroeder Ave. Bel Air*

17 (a) *Burial* (b) Date thereof *Aug. 15 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Perry Hall Methodist*

Location *Perry Hall, Maryland*

18 (a) Funeral director *W. H. Fusting*

Address *3414 Edgemoor Road*

19 (a) *August 14 1943*

(Date rec'd by registrar)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH *August 12 1943 at 1 P.M.*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *Aug. 12 1943* to *Aug. 12 1943*

and that I last saw him alive on *Aug. 12 1943*

20. MEDICAL CERTIFICATION

20. DATE OF DEATH *August 12 1943 at 1 P.M.*

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *Aug. 12 1943* to *Aug. 12 1943*
and that I last saw him alive on *Aug. 12 1943*

Immediate cause of death

Congestive Heart Failure

Due to *Hypertensive Cardia-
Vascular Disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *William H. Fusting*

Address *St. Joseph's Hosp.*

Date signed *8-13-43*

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07222
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4812 Sunbrook Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3307 Cedarhurst

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Anne P. Kattenhorn

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F.

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1943

8. AGE: Years Months Days If less than one day

22

hr.

min.

9. Birthplace Balto City Md

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name Albert F. Kattenhorn

13. Birthplace Balto. Md.

14. Maiden Name Audrey Harris

15. Birthplace Balto. Md.

16 (a) Informant Mrs. A. F. Kattenhorn

(b) Address 4812 Sunbrook Ave.

17 (a) Burial (b) Date thereof Aug 14 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) AUG 14 1943

Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12th 1943, at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1943, to Aug. 12 1943.

and that I last saw her alive on Aug. 12 1943.

Immediate cause of death

marasmus.

Due to Congenital Heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. J. L. S. J. S. J. S.

Address 5407 Belair Rd. Date signed 8-13-43

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY. WITH CORRECT SPELLING. PHYSICIANS: please write the causes of death clearly and legibly. correct age is especially important.

G 07223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07223

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.
(b) Street address
(c) Hospital or institution:
St. Agnes's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1247 Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM OLIVER McNEAL

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-05-0463

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Anna M. McNeal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1880

8. AGE:

Years

Months

Days

If less than one day

63

1

18

hr

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Stone Mason

11. Industry or business

FATHER
MOTHER

12. Name John O. McNEAL

13. Birthplace Baltimore, Maryland

14. Maiden Name Unknown

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Anna M. McNEAL

(b) Address 1174 Cleveland St.

17 (a) Burial (b) Date thereof 8-16-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location 2930 Frederick Rd.

18 (a) Funeral director John J. Conroy & Son

(b) Address 901 Hollins St.

AUG 14 1943
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1943, at 9:50 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. W. J. Conroy & Son M.D.

Date signed 8-13-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 07224

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 510 E. North Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Belle
Mary A. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

E. Widower

6 (b) Name of husband or wife: George Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1876

8. AGE: Years 67 Months 6 Days 1 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own home

12. Name George L. J. Capes

13. Birthplace Md

14. Maiden Name Ellen Vickess

15. Birthplace Md

16 (a) Informant Rev. T. James Capes

(b) Address 510 E. North Ave

17 (a) Burial (b) Date thereof 8-16-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory location
Baptist Church

18 (a) Funeral director J. F. Lickner, Jr.

(b) Address 1200 E. North Ave

19 (a) Date of death AUG 14 1943 (b) Signature of physician

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1943 at 4⁴³ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1943, to Aug 12 1943, and that I last saw her alive on Aug 12 1943.

Immediate cause of death

Toxic hepatitis

Due to obstructive jaundice

Due to ? Carcinoma - pancreas
of or ampulla ?

Other Conditions ? Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Isabella Harrison

Address Church Home & Hospital Date signed 8-12-43

Duration
2 weeks

1 mo

2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07225

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33 + Calvert

(c) Hospital or institution:

Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

75 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3512 N Calvert

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Martha Elizabeth Stromenger

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Sept. 8, 1867

8. AGE:

Years

Months

Days

If less than one day

75

11

4

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

Charles Henry Stromenger

13. Birthplace

Maryland

14. Maiden Name

Mary Nelson

15. Birthplace

Maryland

16 (a) Informant

Mr. Walter N Stromenger

(b) Address

3512 N. Calvert St. City

17 (a)

Burial

(b) Date thereof

8/16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine Cem.

Location

Baltimore Md.

18 (a) Funeral director

WM. J. TICKNER & SONS INC

(b) Address

North & Pa Avs.

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-13

1943. at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943. to Aug 13 1943. and that I last saw her alive on Aug 12 1943.

Immediate cause of death

Cardio-respiratory failure

Due to

sepsis

Due to

Hypertensive Arteriosclerotic cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James H. McColl

M. D.

Address

Union Memorial Hosp

Date signed 8-13-43

AUG 14 1943

G 67226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2116 Pennsylvania Ave(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM H. HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-05-7406

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 15, 1891

8. AGE: Years Months Days

If less than one day

51927

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Bethlehem-FairfieldFATHER
MOTHER

12. Name

Benjamin Harris

13. Birthplace

Balto. Md.

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Virginia Harris

(b) Address

541 Baker St.17 (a) Burial

(b) Date thereof

8/16/43

(Burial, cremation, or removal)

(month, day)

(year)

(c) Cemetery or crematory

Balto Nat

Location

Md.

18 (a) Funeral director

Geo. S. Nelson

(b) Address

1303 Pressman St

19 (a)

AUG 14 1943Huntington Hall, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12, 1943 at 20 M

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature H. Wollenweber M.D.Date signed 8-13-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07227
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Ind* (b) County *Anne Arundel*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *14 Maryland Ave*
(If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME *ADOLPH BEISEL*

3 (b) If veteran, name war *SKD*

3 (c) Social Security Account No. *213-05-5370*

4. Sex *m*

5. Color or race *w*

6 (a) Single, married, widowed, or divorced. *Married*

6 (b) Name of husband or wife *Marie Ziesel*

6 (c) If alive, give age *63* years

7. Birth date of deceased (mo., day, yr.) *6-7-1890*

8. AGE: Years *63* Months *2* Days *6*
If less than one day
hr. min.

9. Birthplace *Maravice Czechoslovakia*
(Town, county, and state)

10. Usual Occupation *Electrician*

11. Industry or business *Work*

FATHER

MOTHER

12. Name *ZIESEL*

13. Birthplace

14. Maiden Name *Marie Kael*

15. Birthplace *Prague CZECHOSLOVAKIA*

16 (a) Informant *Ruby Ziesel*

16 (b) Address *914 ELMRIDGE RD.*

17 (a) *Burial* (b) Date thereof *8-16-43*
(Burial, cremation, or removal) (month) (day) (year)

17 (c) Cemetery or crematory *Harriet Road*
Location *Reston Road*

18 (a) Funeral director *Walter Brooks Bradley Inc*

18 (b) Address *197 25 North Ave*

19 (a) *AUG 14 1943*
(Date rec'd by registrar) *Huntington*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 13 1943* at *7:25 AM*

21. I certify that I took charge of the remains described above, held an *inspection* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH

Rupture of bladder

Due to *Fracture of pelvis*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury *8-8-43* M.
(b) Where did injury occur? *Clinton Ave, same*
(c) Did injury occur at home, on farm, industrial place, in public place? *undetermined* While at work? *Yes*
(d) Means of injury *crushed between cars*

23. Signature *W. Z. Wollanvisher M.D.*
Date signed *8-13-43* *and garden*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1261 4/27/43
7228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07228
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1600 Holbrook St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **Carroll**

(c) City or town **Finksburg**
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Pearl Beatrice Rick

3 (b) If veteran, name war

3 (c) Social Security Account
No. ---

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Henry Rick**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Apr. 7th. 1897**

8. AGE: Years **46** Months **4** Days **5** If less than one day hr. min.

9. Birthplace **Md.**
(Town, county, and state)

10. Usual Occupation **none**

11. Industry or business

12. Name **Edward Doster**

13. Birthplace **Md.**

14. Maiden Name **Susan--**

15. Birthplace **Md.**

16 (a) Informant **Henry Rick**

(b) Address **1600 Holbrook St.**

17 (a) **Burial** (b) Date thereof **Aug. 16/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Baltimore Cem.**
Location **Baltimore Md.**

18 (a) Funeral director **Philip Henry Sons**

(b) Address **2024 Orleans St.**

19 **AUG 14 1943** *W. Williams M.D.*
W. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 12/43** 19 **43** at **5 P M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 7 1943** to **Aug 12 1943** and that I last saw him alive on **Aug 12 1943**

Immediate cause of death

Cardiac insufficiency

Due to **Rheumatoid Disease**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Samuel Quinn**

Address **1415 N. Mos** Date signed **8/14/43**

Duration

?

2

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully suggested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7229
437553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07229
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

60 yrs

3 (a) FULL NAME

Charles V. Ader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

DORA

6 (c) If alive, give age

70 years

7. Birth date of deceased (mo., day, yr.)

6-25-82

8. AGE:

Years

Months

Days

If less than one day

61

1

18

hr.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual Occupation

Baker

11. Industry or business

12. Name

JOHN ADER

13. Birthplace

GERMANY

14. Maiden Name

LOUISE HAMBOLD

15. Birthplace

GERMANY

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof

Aug 16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

Baltimore

18 (a) Funeral director

Philip H. H. H.

(b) Address

2024 Orleans

19 (a) AUG 14 1943

(b) Hunter

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3307 LEVERTON AVE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 12

1943

at 11:43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1943 to Aug 12 1943 and that I last saw him alive on Aug 12 1943.

Immediate cause of death

Pneumonia

Due to

metastatic tumor
? primary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: confirmed above

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. H.

Address

Date signed 8-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07230

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4620 Elserode Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edward H. Rener

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Edna Rener

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-7-1890

8. AGE:

Years

Months

Days

If less than one day

53

5

5

hr.

min.

9. Birthplace

Attomont Md

(Town, county, and state)

10. Usual Occupation

Asst. Max Modler

11. Industry or business

Carnegie Inst

FATHER
MOTHER

12. Name

John

13. Birthplace

Md

14. Maiden Name

Augusta Volz

15. Birthplace

Md

16 (a) Informant

Edna Rener

(b) Address

4620 Elserode Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

8--43
(month) (day) (year)

(c) Cemetery or crematory

Location

Forest Hill
Baltimore Md

18 (a) Funeral director

Leonard P. P. P.

(b) Address

4505 Harford Rd

19

AUG 14 1943
Dr. Wm. H. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4620 Elserode Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-12

1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to 8-12 1943 and that I last saw him alive on 8-11 1943

Immediate cause of death

Hypertrophied left kidney (form of cancer)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

March 1943

Major findings of operation:

Cancer left kidney

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. W. Peake

M. D.

Address

4505 Harford Rd

Date signed

07231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07231

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2720 Bayonne av

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2720 Bayonne

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Katherine J. Hess

3 (b) If veteran, name war

✓

3 (c) Social Security Account

No.

✓

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

John Hess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 20 1864

8. AGE:

Years

Months

Days

If less than one day

78

7

22

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mary Hess (Daughter)

(b) Address

2720 Bayonne av

17 (a)

Burial

(b) Date thereof

8-14-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

Baltimore

18 (a) Funeral director

L. J. Hess

(b) Address

525 Bayonne av

19

AUG 14 1943

Huntington Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 11 1943 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943 to Aug 11 1943, and that I last saw her alive on Aug 11 1943.

Immediate cause of death

Broncho Pneumonia

Duration

9 d

Due to

Chronic Bronchitis & Hyaline Membrane

7 d

Due to

Chronic Interstitial Nephritis

7 d

Other Conditions

Chronic Arteriosclerosis

2 yrs

(Include pregnancy within 3 months of death)

Date of operation

No

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Hess

Address

2720 Bayonne av

Date signed 8/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7232
439497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07232
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State PA (b) County

(c) City or town WAYNESBORO
(If outside city or town limits, write RURAL and give town)

(d) Street No. 137 N. GRANT ST
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LAURENCE W McFERRIN

3 (b) If veteran, name war

3 (c) Social Security Account

No. 204-01-3815

4. Sex

MALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

Nellie

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

4-2-71

8. AGE:

Years

Months

Days

If less than one day

72

4

12

hr.

min.

9. Birthplace

PA

(Town, county, and state)

10. Usual Occupation

MOLDER

11. Industry or business

FATHER
MOTHER

12. Name

George McFERRIN

13. Birthplace

Md

14. Maiden Name

Maggie BEARD

15. Birthplace

Md

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) removal
(Burial, cremation, or removal)

(b) Date thereof Aug. 14, 1943
(month) (day) (year)

(c) Cemetery or crematory

Green Hill

Location

Waynesboro Pa

18 (a) Funeral director

Walter J. Grove

(b) Address

Waynesboro Pa

19 (a) Date of death

Aug 14 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1943 at 445 A

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1943 to Aug 14 1943, and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Coronary Thrombosis
Myocardial Failure

Due to

Angina Pectoris

Due to

Other Conditions

Reverend Protestant

Date of operation

8/13/43

Major findings of operations

of autopsy: ✓

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John S. Harris

Address Johns Hopkins Hosp. Date signed 8/14/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07233

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Ballam King

13. Birthplace Greenville - N.C.

14. Maiden Name Addie Bess

15. Birthplace Greenville - N.C.

16 (a) Informant Mrs. Addie King

(b) Address 9 - N. Mount St.

17 (a) Burial (b) Date thereof 8-14-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Star

Location Culverville - Md.

18 (a) Funeral director Mrs. Kate Williams

(b) Address 322 N. Schuyler

19 (a) Date rec'd by registrar AUG 14 1943

20 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 9 N. Mount St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1943 at 10:53 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1943 to Aug 10 1943, and that I last saw him alive on Aug 10 1943.

Immediate cause of death Phrenetic Heart Disease

Due to

Due to

Other Conditions Mitral Stenosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. S. Danfield

Address Roman Hospital

Date signed 8-14-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07234
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals
14 yrs.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 712 E. Pratt St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

George F. Bennett

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1860

8. AGE: Years

Months

Days

If less than one day

83

6

13

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
MOTHER

12. Name John Bennett

13. Birthplace Md.

14. Maiden Name ?

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof 8/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Sacred Heart of Mary

18 (a) Funeral director John J. Welch

(b) Address 401 S. Chesapeake St.

19 (a) AUG 14 1943

(b) Huntington Hall, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-43 19 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1940 to 8-8 1943, and that I last saw him alive on 8-8 1943.

Immediate cause of death

Cerebral Aneurysm

Duration

1 da

Due to Cerebral Aneurysm

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Paul H. Hatten

Address R. C. 14

Date signed 8/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58720 9
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive (give age) years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.U.R. and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-1943 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/43 to 8/13/43 and that I last saw her alive on 8/13/43

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2200 E Madison

Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07236

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **Wyman Park Drive & 31st St.**
 (c) Hospital or institution:
U. S. Marine Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **2 mos. 14 days**
 (e) Length of stay in Baltimore (yrs., mos., or days) **2 mos. 14 days**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Pa.** (b) County
 (c) City or town **Hanover**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **-** (If rural give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

3 (a) FULL NAME **EUGENE LEROY ALBAN**

- 3 (b) If veteran, name war **War 1941-42-43** 3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Widowed**

- 6 (b) Name of husband or wife **?** 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Mar. 15, 1901**

8. AGE: Years **42** Months **4** Days **30** If less than one day hr. min.

9. Birthplace **Baltimore, Md.** (Town, county, and state)

10. Usual Occupation **Bethlehem Steel Co.**

11. Industry or business **Steel**

12. Name **Eli Alban**
 13. Birthplace **Baltimore County, Md.**

14. Maiden Name **Eugenia German**
 15. Birthplace **Anne Arundel Co., Md.**

- 16 (a) Informant **Records, U.S. Marine Hospital**
 (b) Address **Baltimore, Md.**

- 17 (a) **Burial** (b) Date thereof **8-7-43**
 (Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory **Baltimore**
 Location **East of 6. North Ave**

- 18 (a) Funeral director **4. Lee Alder**
 (b) Address **4644 York Road**

AUG 15 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 14, 1943** at **M**

21. I certify that death occurred on the date above stated; that I attended deceased from **May 1, 1943**, to **Aug. 14, 1943**, and that I last saw him alive on **Aug. 14, 1943**.

Immediate cause of death **Malignant melanoma of the nasal septum with extensive systemic metastases**

Due to **UNK.**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **May 15, 1943**

Major findings of operation: **Malignant melanoma of the nasal septum**

of autopsy: **Yes - As above**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide **No**

- (b) Date of occurrence at **M**

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

- (e) Means of injury

23. Signature **Arthur H. Jones**

- Address **Baltimore, Md.** Date signed **8/14/43**

Va- 13108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR DIVISION

G 07237

BALTIMORE CITY HEALTH DEPARTMENT

G 07237

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2531 Pennsylvania Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ALFRED FINNEY

3 (b) If veteran, name war

World War #1

3 (c) Social Security Account

No. unknown

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1898

8. AGE: Years

55

Months

Days

If less than one day

hr. min.

9. Birthplace

Parkesley, Va.

(Town, county and state)

10. Usual Occupation

Taxi Driver

11. Industry or business

12. Name

Alfred W. Finney

13. Birthplace

Virginia

14. Maiden Name

Bertie W. West

15. Birthplace

Virginia

16 (a) Informant

Drummond Parks (nephew)

(b) Address

Glen Burnie, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8-16-43

(month) (day) (year)

(c) Cemetery or crematory

Location

Parkesley, Va.

18 (a) Funeral director

A. Lee Oder

(b) Address

4644 York Road

AUG 15 1943

(Date rec'd by registrar)

H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1943, at 11 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. A. Wallenmeyer M.D.

Date signed 8-11-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07238

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W. Va. (b) County(c) City or town Martinsburg
(If outside city or town limits, write RURAL and give town)(d) Street No. 4285 Martin St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Hettenhauser, Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Male

5 Color or race

White6 (a) Single, married, widowed, or
divorcedMarried

6 (b) Name of husband or wife

E. Stille

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-14-97

8. AGE: Years

Months

Days

If less than one day

46110

hr.

min.

9. Birthplace

W. Virginia
(Town, county, and state)

10. Usual Occupation

Chain operator

11. Industry or business

FATHER
MOTHER

12. Name

Ges. Hettenhauser

13. Birthplace

W. Va.

14. Maiden Name

Adeline Appie

15. Birthplace

W. Va.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

8-14-43
(month) (day) (year)

(c) Cemetery or crematory

St. Martin's W. Va.
Location

18 (a) Funeral director

F. J. Kechnor

(b) Address

220 E. Madison Ave

AUG 15 1943

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14, 1943 M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from June 29 1943 to Aug 14 1943
and that I last saw him alive on Aug 14 1943

Immediate cause of death

BronchopneumoniaDue to lymphocytic - stem
cell type

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. S. Cross JrAddress S. H. H.Date signed 8-15-43

07239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07239

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3920 Eastern Ave.
(c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

3 (a) FULL NAME

Tillie Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Widow

6 (b) Name of husband or wife Late Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1890

8. AGE: Years

Months

Days

If less than one day

53

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

12. Name

Abraham Atatland

13. Birthplace

Russia

14. Maiden Name

Anna Rogov

15. Birthplace

Russia

16 (a) Informant

William Wolf

(b) Address

3920 Eastern Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof August 15, 1943

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Washington Rd

Location Lansdowne Md

18 (a) Funeral director Soa Levinson & Bros

(b) Address

1124 1126 W North Ave

AUG 15 1943

(Date rec'd by registrar)

(b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3920 Eastern Ave

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1943, at 11 A M21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Aug 14 1943 and that I last saw him alive on Aug 14 1943.

Immediate cause of death

CARCINOMA
(UTERUS)Duration
2 YRS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

At

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 8-14-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07240

ALAN LEFTWICH JEMISON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07240
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balto.
(c) City or town Baltimore
(d) Street No. 2104 N. Charles St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr. Alan Leftwich Jemison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Mrs. Alan L. Jemison
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 26, 1882
8. AGE: Years 61 Months 18 Days 18 hr. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation Finance

11. Industry or business

12. Name William C. Jemison

13. Birthplace Alabama

14. Maiden Name Eliska Leftwich

15. Birthplace Alabama

16 (a) Informant Mr. A. Jemison

(b) Address 2104 N. Charles St.

17 (a) Burial (b) Date thereof Aug 17, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Park
Location Baltimore, Md.

18 (a) Funeral director

223 N. Charles St.

AUG 15 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1943, at 12:22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 AM, Aug 14, 1943, to 12:22 PM, Aug 14, 1943, and that I last saw him alive on Aug. 14, 1943.

Immediate cause of death Coronary thrombosis -
intoxication

Due to Coronary thrombosis 24 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Mungatropo, Jr.

Address 332 E. University Ave. signed 8/14/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. *600 S. Chaptaine*) Ward *25*

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. Home No. If of foreign birth? yrs. mos. da.

2. FULL NAME

Arthur Muogrow

If U. S. Veteran

specify WAR

(a) Residence: No.

600 S. Chaptaine

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. Color or Race <i>W</i>	5. Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
--------------------	------------------------------	--

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day, year) *Don't know*

7. AGE <i>Don't</i>	Years <i>77</i>	Months	Days	If LESS than 1 day, hrs. or min.
------------------------	--------------------	--------	------	--

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Retired Caretaker</i>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year)
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Reisterstown*
(State or country) *md*13. NAME *I turn as Muogrow*14. BIRTHPLACE (city or town) *Baltimore*
(State or country) *md*

15. MAIDEN NAME

16. BIRTHPLACE (city or town)
(State or country)

17. INFORMANT

(Address)

Earl Gore
Reisterstown, md.

18. BURIAL, CREMATION, OR REMOVAL

Place

*Deer Park*Date *Aug. 16 1943*

19. UNDERTAKER

(Address)

Wm. Berryman & Sons
Reisterstown, md.

AUG 15 1943

19.

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *August 14, 1943*22. I HEREBY CERTIFY. That I attended deceased from
November 1, 1942 to *August 14, 1943*I last saw him alive on *August 13, 1943* Death is said
to have occurred on the date stated above, at *8 A.M.*The principal cause of death and related causes of
importance were as follows:*Carcinoma of Rectum**Metastases to Liver*

Other contributory causes of importance

*Jaunderice*Was an operation performed? *No*

Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? *Clinical* Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public
place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed)

Earl Gore

M. D.

(Address) *4001 Williams Ave*

G 07242

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07242

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 15 1943

VB 154

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended
deceased from Aug 15, 1943 to Aug 15, 1943
and that I last saw him alive on Aug 12, 1943

Immediate cause of death

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

8/19/43

WILBECK NOVILE

G 07243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07243

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.U.R. and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1943 to 8/14 1943, and that I last saw him alive on 8/14 1943.

Immediate cause of death Pulmonary
Edema

Due to Spina Arterio & Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed 8/14/43

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 07244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07244

Registered No.

83B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 15 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 14

1943

at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13, 1943, to Aug. 14, 1943, and that I last saw her alive on Aug. 14, 1943.

Immediate cause of death

Vascular collapse

Due to

Bronchopneumonia

Due to

Other Conditions

Hypertension
Old & Recent cerebral thromboses

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G 07245

BALTIMORE CITY HEALTH DEPARTMENT

G 07245

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(d) Street No.

6715 PK. Hgts. Ave

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-07-8926

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Carolyn Lee Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 21-1892

8. AGE:

Years

Months

Days

If less than one day

51

2

22

hr.

min.

9. Birthplace

Russia

(City, county, and state)

10. Usual Occupation

Executive

11. Industry or business

Head Drug Co.

12. Name

Lynne Wilson

13. Birthplace

Russia

14. Maiden Name

Higley

15. Birthplace

Russia

16 (a) Informant

Carolyn Wilson

(b) Address

6715 PK. Hgts. Ave

17 (a) Burial

(b) Date thereof 8-15-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. John's Friendship

Location

18 (a) Funeral director

Joe Harris Inc

(b) Address

1129 E. Balt. St

19 (a)

The Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13

1943 at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1943 to 8/17 1943, and that I last saw him alive on 8/12 1943.

Immediate cause of death

overwhelming sepsis

Due to

broncho-pneumonia

Due to

splenic aneurysm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. Harris

Address

Univ. Hospital

M. D.

Date signed 8/13/43

Correct age is especially important. Please give the exact date of birth, month, day, year, and sex.

G 07246

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07246

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Woodlawn Rd Poland Park Ward)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

Maudie Latham Benson(a) Residence: No. 108 Woodlawn Road St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) widowed

6a. If married, widowed, or divorced (or) WIFE of

Charles J Benson

4. DATE OF BIRTH (month, day, year)

March 11, 1876

7. AGE

Years

Months

Days

If LESS than

6753

1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Home

10. Date deceased last worked at this occupation (month and year)

June 12, 1942

11. Total time (years) spent in this occupation

Life

12. BIRTHPLACE (city or town) (State or country)

BaltimoreMaryland

MOTHER

13. NAME

Jessie Susan Elsworth

14. BIRTHPLACE (city or town) (State or country)

BaltimoreMaryland

15. MAIDEN NAME

Ella Hallock

16. BIRTHPLACE (city or town) (State or country)

BaltimoreN.Y.

17. INFORMANT

(Address)

Ella Chape Elsworth
108 Woodlawn Road

18. BURIAL, CREMATION, OR REMOVAL

Place

Green Ridge

Date

Aug 16, 1943

19. UNDERTAKER

(Address)

Henry W Jenkins & Son
McCallister Orchard St.

20. FILED

Thurston Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 14, 1943

22. I HEREBY CERTIFY, That I attended deceased from

June 1942 to August 14, 1943I last saw her alive on August 13, 1943 Death is saidto have occurred on the date stated above, at 3 1/2 p. m.

The principal cause of death and related causes of importance were as follows:

Arterio-sclerosis - cerebral
Cerebral Hemorrhage

Date of onset

19421942

Other contributory causes of importance:

noneWas an operation performed? no

Date of

For what disease or injury? no

Name of operation

Date of

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—Where did injury occur? —

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public

place

Manner of injury —Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Francis W. Bluck M. D.

(Address)

715 Park Ave

UG 15 1943

G 07247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07247
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1506 Jackson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Margaret W. Liston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color of skin

White

6 (a) Single, married, widowed, divorced

Married

(b) Name of husband or wife

Daniel G. Liston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 23, 1882

8. AGE:

Years

Months

Days

If less than one day

60

9

20

19 min.

9. Birthplace

Belair Ohio

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

James Loftus

13. Birthplace

Ireland

14. Maiden Name

Mary Manley

15. Birthplace

W. Virginia

16 (a) Informant

Mr Daniel G. Liston

(b) Address

1506 Jackson St.

17 (a)

Burial

(b) Date thereof

8-16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore Md.

18 (a) Funeral director

Flynn + Fleming

AUG 15 1943

(Date rec'd by registrar)

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1506 Jackson

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/12

1943 at 2 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1943 to 8/12 1943

and that I last saw her alive on 8/12 1943

Immediate cause of death

Cerebral Thrombosis

Due to

Due to

Other Conditions

arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Samuel Rubin

M. D.

Address

2038 E. St.

Date signed

G 07248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07248
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 724 W. Cross St.
 (c) Hospital or institution: ✓
 (d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
 (e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 724 W. Cross St.
 (If rural give location)
 (e) If foreign born, how long in U. S. A. — years

3 (a) FULL NAME

George E. Hayslup
 3 (b) If veteran, name war — 3 (c) Social Security account No. —

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
 6 (b) Name of husband or wife Pauline C. Hayslup 6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 17 - 1877

8. AGE: Years 65 Months 9 Days 27 hr. 26 min. —
 If less than one day

9. Birthplace Baltimore Md.
(City, county, and state)10. Usual Occupation Reporter11. Industry or business Bethlehem Steel (Key Highway)12. Name Thomas Hayslup13. Birthplace Balto. Md.14. Maiden Name Sophia forty15. Birthplace Balto. Md.16 (a) Informant Pauline Hayslup(b) Address 724 W. Cross St.17 (a) Burial (b) Date thereof 8-17-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. OlivetLocation Baltimore Md.18 (a) Funeral director Flannery & Flannery(b) Address 1426 Light St.

AUG 15 1943

(Date rec'd by registrar) William Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943, at 11:40 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1942 to Aug 13 1943 and that I last saw him alive on Aug 13 1943.

Immediate cause of death

Auricular FibrillationDue to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury Heart Attack23. Signature Harry KatoAddress 517 Scott St. Date signed Aug 14/43

Duration

1 1/2 yrs.3 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07249

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

8

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

Baltimore

(d) Street No.

2226 Lake Avenue

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Madelini

Klaes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W. Long

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 9 - 1894

8. AGE:

Years

Months

Days

If less than one day

49

5

5

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Insurance

FATHER
MOTHER

12. Name

Philip Stammer

13. Birthplace

Germany

14. Maiden Name

Catherine Kist

15. Birthplace

Baltimore

16 (a) Informant

Margaret Stammer

(b) Address

2226 Lake Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof Aug 17 - 1943

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

18 (a) Funeral director

Charles P. Towell

(b) Address

3427 Edmond St. E

19 (a) Date rec'd by registrar

August 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 14 1943 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to Aug. 14 1943, and that I last saw him alive on Aug. 14 1943.

Immediate cause of death

Cerebral hemorrhage
Head of pancreas

Due to

Due to

Other Conditions

(Include pregnancy within 1 month of death)

Date of operation

8-15-43

Major findings of operation:

Ca. of head of pancreas
of autopsy: Ca. of head of pancreas

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. B. Kijamovics

Address

St. Joseph's Hospital

Date signed

PLEASE WRITE PRINTED NAMES OF PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. correct age is especially important.

G 07250

FRANK Popesko X ✓
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 127a

Registered No. G 07250

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~3018~~ Wilkens & Calver Ave

(c) Hospital or institution:

St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3018

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Popesko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Lena Popesko

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 4 - 1890

8. AGE:

Years

Months

Days

If less than one day

58

3

10

hr.

min.

9. Birthplace

Austria Hungary

(Town, county, and state)

10. Usual Occupation

Steel worker

11. Industry or business

M & Steel

FATHER

12. Name

Keroman Popesko

13. Birthplace

Austria Hungary

14. Maiden Name

Pich

15. Birthplace

Austria Hungary

16 (a) Informant

Lena Popesko

(b) Address

3018 Wilkens Ave. Baltimore

17 (a)

Burial

(b) Date thereof

Aug - 18 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore, Md.

18 (a) Funeral director

William Popesko, Inc.

(b) Address

1217 St Paul St.

19 (a)

AUG 16 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/14/43

19.43, at 11 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/9/43 to 8/14/43, and that I last saw him alive on 8/14/43.

Immediate cause of death

Nystic Shock

Due to

Cholecystitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8/14/43

Major findings of operation:

acute

of autopsy:

not done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Howard W. Sher

Address

St Agnes Hospital

Date signed 8/16/43

PLEASE WRITE PLAINLY, WITH CARE. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07251
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 1/2 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. Abbey Hotel - 713 St. Paul St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Marianna

Ramos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Ralph Ramos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1878

8. AGE:

Years

Months

Days

If less than one day

65

4

0

hr.

min.

9. Birthplace Ponce

Porto Rico

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name (Unknown)

Laboy

13. Birthplace

Porto Rico

14. Maiden Name

15. Birthplace

16 (a) Informant

Mrs. Hilma Ramos (Daughter)

(b) Address 713 St. Paul St.

17 (a) Burial

(b) Date thereof 8/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. Paul St.

19 AUG 16 1943

(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1943 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1943 to Aug. 15 1943, and that I last saw her alive on Aug. 15 1943.

Immediate cause of death

Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William H. Fusting

Address

St. Joseph's Hosp.

Date signed 8-16-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

7252

JL - 83097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07252
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1637 N. Carey St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Middleton Baby Boy (Frances)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 7, 1943

8. AGE: Years

Months

Days

If less than one day

18

hr.

min.

9. Birthplace B. C. H. Balto, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Robert Smith

13. Birthplace Md.

14. Maiden Name Frances Middleton

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Cremation
(Burial, cremation, or removal)(b) Date thereof 8-12-43
(month) (day) (year)

(c) Cemetery or crematorium Baltimore City Hospitals

Location 4940 Eastern Ave, Baltimore

18 (a) Funeral director

Maryland

AUG 16 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1943, at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1943 to 8-8 1943, and that I last saw him alive on 8-8 1943

Immediate cause of death

Congenital Atelectasis

Duration

1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 8-8-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 Registered No. 07254

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Male white

5. Color

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1943, 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

congenital atelectasis
Due to premature birth
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Leodore Horvath 8/12/43
West Baltimore New Hope

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 16 1943

VB 150

(b) Huntington Williams, M.D.

0288

G 07255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07255
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943. at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1943, to 8/15 1943, and that I last saw her alive on 8/15 1943.

Immediate cause of death Diabetes Coma

Duration

Due to

Due to

Other Conditions Pneumonia

Hypertension C.V.D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 8/16/43

M. D.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

Ralph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1883

8. AGE: Years Months Days If less than one day
60 hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Edward Berkenfeld

13. Birthplace Poland

14. Maiden Name Rose

15. Birthplace Poland

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (b) Date thereof 8-16-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment

Location Park Rd. & Hamilton Ave

18 (a) Funeral director

(b) Address

19 (a) AUG 16 1943

(Date rec'd by registrar)

Registrar

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 07256

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07256
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3003 Woodland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3003 Woodland Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

LLEWELYN H. ULBARSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Martha Lee Schaceman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/23/1884

8. AGE:

Years

Months

Days

If less than one day

57

5

21

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

C. P. A.

12. Name

Jacob -

13. Birthplace

Russia

14. Maiden Name

Rebecca -

15. Birthplace

Russia

16 (a) Informant

Mrs. Martha Lubarsky

(b) Address

3003 Woodland Ave.

17 (a) Burial

(b) Date thereof 8-16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Spring Mt. J. R. Rose

Location

Windsor Hill Rd.

18 (a) Funeral director

Joe Hews Inc.

(b) Address

1739 E. Baltimore St.

19 (a)

AUG 16 1943

(Date received)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-14-43

19

4 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13, 1943 to Aug. 14, 1943.

and that I last saw him alive on Aug. 13, 1943

Immediate cause of death

Coronary disease

Due to

Due to

Other Conditions

Parkinson's disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Jack J. Singer

Address

506 E. North Ave

Date signed

8/15/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 07257
Registered No.

125B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3027 Eleny Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

Md Baltimore
7013 Harford Rd
Yes or No

3 (a) FULL NAME

Marguerite Adel Kinnear

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Registrar

AUG 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 13 1943, 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943, to Aug 13 1943, and that I last saw her alive on Aug 13 1943.

Immediate cause of death

Toxic Hepatitis - with
Jaundice & Hepatomegaly

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

L. Harrell Price
5106 Harford Rd
Baltimore, md

Duration

4 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physician: please write the cause of death clearly and legibly.

07258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07258
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 15 1943 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1943 to Aug 15 1943 and that I last saw her alive on Aug 15 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

8/16/43

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07259

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 13 1943 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1940, to Aug. 1943,

and that I last saw him alive on Aug. 13, 1943.

Immediate cause of death

Duration

4 days

Due to

Cerebral Hemorrhage

3 years

Due to

Other Conditions

My performance excellent

?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Leland Brill

Address

826 N Washington St

Date signed 8/13/43

PLEASE WRITE FOR CORRECTNESS. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AUG 16 1943

Huntington Williams

SM G 07260
82132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07260
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 65 days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

3 (a) FULL NAME

Vincent Waiczunicas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1885

8. AGE: Years

58

Months

2

Days

14

If less than one day

hr.

min.

9. Birthplace Lithuania

(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER
MOTHER

12. Name Anthony Waiczunicas

13. Birthplace Lithuania

14. Maiden Name Katherine Gustailis

15. Birthplace Lithuania

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 16 43

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location

Black Rd

18 (a) Funeral director Joseph Rasnakevich

(b) Address 602 W. Washington St

19 (a) AUG 16 1943 Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 415 W. Pratt St.

(If rural, give location)

(e) Citizen of foreign country? Lithuania (Yes or No)

If yes, name country

Lithuania

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1943 at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1942 to 8-13 1942, and that I last saw him alive on 8-12 1942.

Immediate cause of death

Brachycephalus

Due to

Due to

Other Conditions Pinkish

of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Mattina

Address

B. C. H.

Date signed

M. P.

8/13/43

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LOGICALLY. correct age is especially important.

G 07261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07261

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4402 Parkmont Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County B(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4402 Parkmont

(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Thomas6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Feb 11th 18908. AGE: Years 73 Months 6 Days 4

If less than one day

hr.

min.

9. Birthplace Balto. City Md.

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name George Leonard13. Birthplace Balto. Md.14. Maiden Name Virginia Pabst15. Birthplace Balto. City Md.16 (a) Informant Adelia Fulmer(b) Address 4402 Parkmont Ave.17 (a) Burial (b) Date thereof Aug 18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory ParkwoodLocation Balto. Md.18 (a) Funeral director Fassaby Funeral Home(b) Address 7401 Belair Rd.19 (a) AUG 16 1943 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1943. at 1:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1943 to 8-15 1943 and that I last saw her alive on 8-15 1943.

Immediate cause of death

Acute myocarditisDue to Probable VirusPneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature L. W. DeakeAddress 4508 Hayford Rd.

M. D.

Date signed 8-15-43

Duration

9 days7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07262

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 3320 Auchentoroly Terrace
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
- (e) Length of stay in Baltimore (yrs., mos., or days) 8 46

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
- (c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 3320 Auchentoroly Terrace
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

JOSEPH ARCHER

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. 212-14-2957

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Carolina W. Archer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24, 1868

8. AGE: Years Months Days If less than one day

74 11 19 hr. min.

9. Birthplace Trenton N. J.

(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Archer Laundry Co.

12. Name unknown Archer

13. Birthplace Unknown

14. Maiden Name unknown Parker

15. Birthplace N. J.

16 (a) Informant Mr. Joseph E. Archer

(b) Address 413 E. Lake Ave.

17 (a) Burial (b) Date thereof 8/16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director M. J. TICNER & SONS INC.

(b) Address North & Pa Aves.

19 AUG 16 1943

Huntington, N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1943 to Aug 13 1943, and that I last saw him alive on Aug 13 1943.

Immediate cause of death

Acute Cardiac
Dilatation.

Due to

myocarditis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
- (e) Means of injury

23. Signature

Address 76 Cathedral St Date signed 8.15.43

Duration

5 min.

2 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07263

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3906 Reisterstown Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3906 Reisterstown Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Elias Welch

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary C. Welch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1867

8. AGE: Years Months Days If less than one day

76

0

12

hr.

min.

9. Birthplace Carroll Co., Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance

12. Name Samuel Welch

13. Birthplace Carroll Co., Md.

14. Maiden Name Sarah Ann Ogg

15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Mary C. Welch

(b) Address 3906 Reisterstown Rd.

17 (a) Burial (b) Date thereof 8/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.

(b) Address North & Pa. Aves., Balto., Md.

19 (a) (b)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1943 19 at 9:30 A

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 3-6-1943 to 8-14-1943.

and that I last saw him alive on 8-14-1943

Immediate cause of death

Hypertension
Cardiovascular disease
Due to Arteriosclerosis
Nephritis

Due to

General Arteriosclerosis

Other Conditions Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James S. Atchurst M. D.

Address 4012 Park Heights Date signed 8-14-43

Duration 48 hrs

3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECTION. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AUG 16 1943

G 07264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07264

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 1421 Homestead St.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 73 Years

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1421 Homestead St.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

ANNIE L. YOCKEL

- 3 (b) If veteran, name war NONE
- 3 (c) Social Security Account No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Single

- 6 (b) Name of husband or wife Single
- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 10, 1869

8. AGE: Years 73 Months 9 Days 4 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Augustus W. Yockel

13. Birthplace Germany

14. Maiden Name Susan Tanner

15. Birthplace Carroll Co. Md.

- 16 (a) Informant Mrs. Mary Yockel

- (b) Address 1601 McKean Ave.

- 17 (a) Burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory New Cathedral
Location Baltimore Md.

- 18 (a) Funeral director WM. J. TICKNER & SONS INC.

- (b) Address North & Pa Aves.

- 19 (a) (b)
(Date rec'd by registrar)

VS 144

AUG 16 1943

Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 43 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1942 to 8/14 1943 and that I last saw him alive on 7 19 43

Immediate cause of death

Cancer stomach, etc

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur?

(City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

- (e) Means of injury

23. Signature

Address

1421 Pa Ave

Date signed 8/14/43

JAMES FRANKEL, A.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly.

G 07265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07265

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison & Howard*

(c) Hospital or institution:

Maryland General(d) Length of stay in hospital or inst. (year, month, or days) *9*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3803 W. Garrison*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Grace Isabel Reidmaier

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or

divorced. *Married*6 (b) Name of husband or wife *Harry Reidmaier*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan. 24, 1885*

8. AGE: Years

58

Months

6

Days

20

If less than one day

hr.

min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation *H. W. Housewife*

11. Industry or business

12. Name *Joseph Hoffman*13. Birthplace *Pa.*14. Maiden Name *Albina Huhn*15. Birthplace *Md.*16 (a) Informant *Mr. Harry Reidmaier*(b) Address *3803 Garrison*17 (a) *Burial*(b) Date thereof *8/16/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Druid Ridge*Location *Baltimore Md.*18 (a) Funeral director *WM. J. TICKNER & SONS INC.*(b) Address *North & Pa Aves.*19 (a) *AUG 16 1943*

(b)

Huntington Williams

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 14, 1943*, at *1:25* *A*21. I certify that death occurred on the date above stated; that I attended deceased from *August 5, 1943*, to *August 14, 1943* and that I last saw him alive on *August 13, 1943*.

Immediate cause of death

*Hypostatic
Pneumonia*

Due to

Circosis of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *B. Herman Williams*

M. D.

Address *Md. Oak St.* Date signed *August 14*

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07266

438538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07266

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **20 D.**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 16 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country

(If rural, give location)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 14

1943 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943 to Aug 15 1943

and that I last saw

live on Aug 15 1943

Immediate cause of death

Unknown

Duration

Due to

Due to

Other Conditions

Hypothyroidism 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Diffuse toxic goiter

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George Bunch

Address

Johns Hopkins Hospital

Date signed

8-14-43

G 07267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07267

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *N. Broadway*

(c) Hospital or institution:

Church Home and Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 1/5*(e) Length of stay in Baltimore (yrs., mos., or days) *58*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *2813 Norfolk Avenue*
(If outside city or town limits, write RURAL and give town)(d) Street No. *Baltimore*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harvey A. Warner

3 (b) If veteran, name war

3 (c) Social Security Account

No. *212-10-3586*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Emma Warner*6 (c) If alive, give age *62* years7. Birth date of deceased (mo., day, yr.) *March 31, 1881*

8. AGE:

Years

Months

Days

If less than one day

*62**4**14**13*

hr.

min.

9. Birthplace *Maryland*

(Town, county, and state)

10. Usual Occupation *Manager*11. Industry or business *Insurance*

FATHER

12. Name Dr. *A.S. Warner*13. Birthplace *MD.*

MOTHER

14. Maiden Name *Florence Eisenberger*15. Birthplace *Pennsylvania*16 (a) Informant *Hospital*(b) Address *2813 Norfolk Ave*17 (a) *Burial*(b) Date thereof *Aug 17/43*

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematorium

Location *3801 Frederick Ave*

18 (a) Funeral director

(b) Address *1900 Eutaw Place*

19 (a)

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 14 1943 at 10:30 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *August 12 1943* to *August 14 1943*, and that I last saw him alive on *August 14 1943*.

Immediate cause of death

Cerebral Hemorrhage

Duration

5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Ernest*Address *Church Home and Hospital* Date signed *8/15/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 16 1943

G 07268

82348

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07268

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1616 Druid Hill Av.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Hattie Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Samuel Simms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1878

8. AGE: Years Months Days If less than one day

65

2

29

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

12. Name Gus Sissomis

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof Aug 17-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

AUG 16 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-13 1943 10 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 1943 to 8-13 1943, and that I last saw him alive on 8-13 1943.

Immediate cause of death

Pneumonia

Due to Intertoracic Fracture

Due to Rt Hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 8-13-43 at M

(c) Where did injury occur? Baltimore City

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home

(Specify type of place) While at work?

(e) Means of injury Fall on floor

23. Signature Donald R. Webb

Address Baltimore City

Date signed 8-14-43

Duration

4 days

3 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H. J. Wollenweber M.D. Asst Medical Examiner

G 07269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07269
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *416 Worsley St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *45 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *416 Worsley St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Harriett Moore

3 (b) If veteran, name war

3 (c) Social Security Account

No. *None*

4. Sex

Female Col

5. Color or race

6 (a) Single, married, widowed, or

divorced *Widow*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 25-1875

8. AGE:

Years

Months

Days

If less than one day

*67 68**7**17*

hr.

min.

9. Birthplace

Ashland Co Virginia

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

FATHER

12. Name

Stephen Winston

13. Birthplace

VA

MOTHER

14. Maiden Name

Margaret P

15. Birthplace

VA

16 (a) Informant

James Devine

(b) Address

*3000 Hunter St*17 (a) *Burial*

(b) Date thereof

8 10 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arbutus

Location

Menomona Park

18 (a) Funeral director

Paymer Sanders

(b) Address

1412 E. Preston St

19 (a)

(b)

AUG 10 1943

VS 144

William

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 12 1943* at *9 30 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *Apr 1 1942* *Day 12 49 PM*and that I last saw him alive on *19*

Immediate cause of death

Relapsing Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Paul A. Johnson*Address *2329 E. Preston St*Date signed *Aug 12 1943*

M. D.

18 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07270

439517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07270

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Susie

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

9-6-10

8. AGE:

Years

Months

Days

If less than one day

32

11

7

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

John Scott

13. Birthplace

Va.

MOTHER

14. Maiden Name

Maggie Hancock

15. Birthplace

Va.

16 (a) Informant

Reverend

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

8/15/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt Zion

Location

Charlotte, Va.

18 (a) Funeral director

Uroy O. Wilson

(b) Address

1000 Brentley Ave

19

AUG 16 1943

(b)

Huntington Williams

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1307 E. Madison ST.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 13

1943

at 12:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 12, 1943, to August 17, 1943, and that I last saw him alive on August 13, 1943.

Immediate cause of death

Respiratory failure

Due to

Circulatory collapse

Due to

Enterovirus, later type II

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ephraim Gonsky

Address

Johns Hopkins Hospital

Date signed

M. D.

8/13/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07271

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 115 S. Bond St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Willie Lawrence Dempsey

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-43

8. AGE: Years Months Days If less than one day

79 hr. min.9. Birthplace md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Claude Dempsey13. Birthplace N.C.

MOTHER

14. Maiden Name Sarah Green15. Birthplace N.C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof 8/16/43
(month) (day) (year)(c) Cemetery or crematory McCalvary

Location

18 (a) Funeral director Elroy WilsonBlumenthal and19 AUG 16 1943
(Date rec'd by registrar)

VB 110

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943 3:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1943 Aug. 13 1943 and that I last saw him alive on Aug. 13 1943

Immediate cause of death

myocardial infarction
Due to atherosclerosisDue to infected umbilical site

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)(e) Means of injury Robert Kaye23. Signature John H. H. H. H.Address John H. H. H. H.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH6 07272
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1118 Russell St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Flora Lomax

83007

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
female5. Color or race
black6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife Melvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1911

8. AGE: Years 32 Months 3 Days 21
If less than one day hr. min.9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Perry

13. Birthplace Md.

14. Maiden Name Sarah Carey

15. Birthplace Md.

16 (a) Informant Hospital records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/16/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Chas O. Wilson

(b) 1000 Brantley Ave

19 AUG 16 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1943 at 12:05 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 3 19 43 to Aug. 13 19 43,
and that I last saw her alive on Aug. 13 19 43.

Immediate cause of death

Pulmonary tuberculosis

Duration

1 yr 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Hatt

Address R.C.F.

Date signed 8-13-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

07273

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1428 McCallum St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1428 McCallum St
(If rural give location)(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME

HENRY DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

colored

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Evelyn Daniels

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5/16/1889

8. AGE:

Years 54

Months 2

Days 29

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Labourer

11. Industry or business

FATHER
MOTHER

12. Name

Luke Daniels

13. Birthplace

N. Carolina

14. Maiden Name

Silla Laughery

15. Birthplace

North Carolina

16 (a) Informant

Evelyn Daniels

(b) Address

1428 McCallum St

17 (a)

Burial

(b) Date thereof

8/17/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt Calvary

Location

18 (a) Funeral director

Elroy Wilson

(b) Address

1000 Bedford Ave

AUG 16 1943

(b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 15 1943 at 1:07 PM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. Z. W. Wallenmeyer M.D.

Date signed 8-16-43

07275
JL- 81975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07275
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

3 (a) FULL NAME

William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1867

8. AGE:

Years 75

Months 8

Days 7

If less than one day

hr. min.

9. Birthplace Illinois

(town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

12. Name

John Johnson

13. Birthplace

Illinois

14. Maiden Name

Emily

15. Birthplace

Illinois

16 (a) Informant B. O. H. Records

(b) Address 4940 Eastern Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof Aug 16 1943

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 16 1943

VB 154

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 622 George St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.12 1943 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1943 to 8-12 1943, and that I last saw him alive on 8-12 1943

Immediate cause of death

Pneumonia

Due to

Arteriosclerotic Gangrene

Due to

Sen. Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8.10.43

Major findings of operations: Gangrene

et Joe F

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature David B. Hutt

Address Baltimore City Hospital Date signed 8.13.43

7276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07276
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Registrar

(b) Registrar

20 (a) Registrar

(b) Registrar

21 (a) Registrar

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 07277**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **237 1/2 S. Stricker St**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County

(c) City or town **Baltimore**
(If outside city or town line, write RURAL and give town)

(d) Street No. **237 1/2 S. Stricker St**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
66 2 - hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) **Burial**

(b) Date thereof **Aug 18, 1943**
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 16 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8/15** 19 **43** at **8:45** A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from **8/17** 19 **43** to **8/15** 19 **43**, and that I last saw him alive on **8/17** 19 **43**.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **D. J. Zubinski**

Address **5217 Parkmouth Rd.** Date signed **8/15/43**

Duration

2 days

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07278
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1727 Ruston Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *15*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Loretta M. Koch

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

*White*6 (a) Single, married, widowed, or
divorced.*single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace *Martinsburg W. Va.*

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER12. Name *William Koch*13. Birthplace *W. Va.*14. Maiden Name *Catherin*15. Birthplace *W. Va.*16 (a) Informant *Miss. Annie Koch*(b) Address *1727 Ruston Ave.*17 (a) *Burial* (b) Date thereof *8/17/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *St. Joseph's*Location *Martinsburg W. Va.*18 (a) Funeral director *Martin Baker & Son*(b) Address *1827 W. North Ave.*19 (a) (b) *Antington Williams*

AUG 16 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1727 Ruston*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 13 1943* at *9 P.M.*21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *April 1942* to *Aug 1943*
and that I last saw him alive on *Aug 13 1943*

Immediate cause of death

*Rectal tumor*Due to *Carcinoma with
metastases*

Due to

Other Conditions *(over)*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)(e) Means of injury *M. E. Needle*

23. Signature

Address *2314 - W. North Ave.* Date signed *8/16/43*

Duration

1 yr.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07279

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ROLAND

HARVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1940

8. AGE:

Years

Months

Days

If less than one day

3

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Roland Harvey Sr.

13. Birthplace

Baltimore

MOTHER

14. Maiden Name Lutter by Sr.

15. Birthplace

(Baltimore) Mt. Vernon Co. Md.

16 (a) Informant

Roland Harvey

(b) Address

1107 Park St

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

8/14/43

(c) Cemetery or crematory

Mt. Auburn

Location

West park Ind

18 (a) Funeral director

E. S. Hollander

(b) Address

1107 Park St

(Date rec'd by registrar)

August 16 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1107

Park St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 14 1943, at 1:25 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-14-43

1:25 PM

(b) Where did injury occur?

Bryce Ave near

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?

(d) Means of injury

pedestrian struck by

23. Signature

H. Z. Wollenweber M.D.

Date signed

8-14-43

Auto Truck

G 07280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 431 S. Durham Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 S. Durham Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME

SOPHIA SLOWIKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Teofil
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 64 Months Days If less than one day
hr. min.

9. Birthplace Zaromin, Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Franciszek Zytowieski13. Birthplace Zaromin, Poland14. Maiden Name Unknown15. Birthplace Poland16 (a) Informant Mr. Teofil Slowikowski(b) Address 431 S. Durham Street

17 (a) Burial (b) Date thereof Aug. 17, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy RosaryLocation German Hill Road18 (a) Funeral director M. J. Sadowski Sons(b) Address 1808 Eastern Ave.

AUG 16 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943, at 5:40 p. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1943, to Aug 13 1943, and that I last saw him alive on Aug 13 1943.

Immediate cause of death

Pulmonary edema
myocardial segmentDue to sky pneumonia

Due to

Other Conditions Residual of lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 24 S. BroadwayDate signed Aug 16/43

Duration

1 day1 yr1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07281

Registered No.

PLACE OF DEATH: 2909 White Ave.
Baltimore City, Maryland

(b) Street address 2909 White Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 80 years

3 (a) FULL NAME

Agnes Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-1862

8. AGE: Years 81 Months 80 Days 5 If less than one day 27 hr. min.

9. Birthplace Balto

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name Wm Andrews

13. Birthplace Md

14. Maiden Name Mary Morgan

15. Birthplace Md

16 (a) Informant Mrs Clara G. Andrews

(b) Address 2909 White Ave

17 (a) Burial (b) Date thereof 8-17-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Leonard J. Ruch

(b) Address 530 E. Pratt St. Baltimore

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

VS 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2909 White Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A? years

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943 at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 13 1943 to August 13 1943, and that I last saw her alive on 1940.

Immediate cause of death

Chronic Myocarditis

Duration

5 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. W. Peake

Address 4508 Harford Road Date signed 8-15-43

Approved: Robert L. Graham M.D.

H. 07282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3300 Batavia Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 71

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3300 Batavia Ave

(If rural give location)

(e) Citizen of foreign country? Batavia (Yes or No)

If yes, name country

3 (a) FULL NAME

Amelia H. Meisenhalter

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Fm

5. Color or race

W

6 (a) Single, married, widowed, or
divorced

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-1878

8. AGE: Years Months Days If less than one day

64

8

25

hr.

min.

9. Birthplace

Balt Md
(Town, county, and state)
at home

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Simon Meisenhalter

13. Birthplace

14. Maiden Name Pauline Meisenhalter

15. Birthplace

16 (a) Informant Mrs Pauline Meisenhalter

(b) Address 3300 Batavia Ave

17 (a) Burial, cremation, or removal

(b) Date thereof 8-16-47

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address 5305 Harbor Rd

19 (a) (Date and by registrar)

(b) Huntington, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-13- 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Jan-1943, to Aug-13- 1947,
and that I last saw him alive on Aug-11- 1947.

Immediate cause of death

Pneumonia Tuberculosis.

Due to

Due to

Other Conditions (Cardiovascular)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. Brooks Bayle

Address 5217 Harbor Rd Date signed Aug-13-1947

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

AUG 16 1947

~~G 07283~~
607283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

~~G 07283~~
Registered No. 607283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 5306 Sipple Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5306 Sipple Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country Sippel

3 (a) FULL NAME

Barbara R. Christ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

W F

7. Birth date of deceased (mo., day, yr.) 11-2-1869

8. AGE: Years 73 Months 9 Days 11 hr. min.

9. Birthplace

Balt. Md
(Town, county, and state)
at home

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Peter A. Mecher

13. Birthplace

14. Maiden Name

Margaret Bosch

15. Birthplace

16 (a) Informant

Barbara R. Christ

(b) Address

5306 Sipple Ave

17 (a)

Burial, cremation, or removal

(b) Date thereof

8-16-42
(month) (day) (year)

(c) Cemetery or crematory

Location

Holy Redeemer
Balt. Md

18 (a) Funeral director

(b) Address

Seamans Block
1205 W. 1st St

19 (a)

(Date rec'd by registrar)

(b)

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 13, 1942 at 2:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 5, 1942, and that I last saw him alive on Aug. 13, 1942.

Immediate cause of death

Cerebral hemorrhage

Due to

arteriosclerosis

Due to

hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Thos. J. [Signature]

Date signed 8-14-42

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 16 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

607284

540

607284

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 1039 Bold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1039 Bold Spring Lane
(If rural give location)
(e) Citizen of foreign country: No. (Yes or No)
If yes, name country:

3 (a) FULL NAME

Joseph Fedral

3 (b) If veteran, name was

3 (c) Social Security Account

No. 2-12-22-7299

Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie D. Fedral

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 13-1890

8. AGE: Years: 53 Months: 4 Days: 1 If less than one day hr. min.

9. Birthplace: Baltimore, Maryland

10. Usual Occupation: Cabinet Maker

11. Industry or business

12. Name: Frank Fedral

13. Birthplace: Czechoslovakia

14. Maiden Name: Barbara Kaplan

15. Birthplace: Czechoslovakia

16 (a) Informant: Mrs. Jennie D. Fedral

(b) Address: 1039 Bold Spring Lane

17 (a) Burial (Burial, cremation, or removal): Burial

(b) Date thereof: Aug 17-1943

(c) Cemetery or place of interment: Loudon Park

Location: Baltimore, Md.

18 (a) Funeral director: Gurgee Funeral Home

(b) Address: 3631 Falls Road

19 (a) Date of death: AUG 16 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 14-1943 at 2:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1942 to 8-13 1943 and that I last saw him alive on 8-13 1943.

Immediate cause of death: Coma and respiratory arrest

Due to: Brain Tumor

Due to: (none)

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Dec 28-42 July 7-43

Major findings of operations: Cerebral

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Myer A. Wernberg M. D.

Address: 8-14-43 Date signed:

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of face

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 42, at 12:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 41, to Aug 1, 19 42, and that I last saw him alive on Aug 1, 19 42.

Immediate cause of death

Intermittent P.V. Disease

Duration

5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1013 W 36th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1013 W 36th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Harry Arhos

3 (b) If veteran, name war

☒ Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Olga Arhos

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 7 1886

8. AGE: Years 57 Months 6 Days hr. min.

9. Birthplace

Greece

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Cleaning & Dressing

12. Name Wm Arhos

13. Birthplace

Greece

14. Maiden Name Helen Kanas

15. Birthplace

Greece

16 (a) Informant Olga Arhos

(b) Address 1013 W 36th St

17 (a) Burial (b) Date thereof Aug 18/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Chenoweth & Sonoran

(b) Address 3615-12 B. Kenton Ave

19 (a) Date rec'd by registrar AUG 16 1943 (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

30

20. DATE OF DEATH August 15, 1943 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to Aug 1943, and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Cancer of left lung.
Metastatic

Duration

2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert B Taylor

Address 104 W. Madison St Date signed Aug 16 43

6.07287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G-87285

Registered No. 3698

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1411 Edmoreon ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

19

(e) Length of stay in Baltimore (yrs., mos., or days)

20 yrs

3 (a) FULL NAME

Mrs Martha Jane Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Joseph Lee

6 (c) If alive, give age

Unknown years

7. Birth date of deceased (mo., day, yr.)

Feb. 21 1875

8. AGE:

Years

Months

Days

If less than one day

68

5

21

hr.

min.

9. Birthplace

Lancaster Co. Va

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

own home

12. Name

Richard Lee

13. Birthplace

Va

14. Maiden Name

Louisa Campbell

15. Birthplace

Va

16 (a) Informant

Joseph Lee

(b) Address

1411 Edmoreon ave

17 (a) Burial

Aug 19-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arlington Memorial

Location

Ft. St.

18 (a) Funeral director

Sam W. Chase Jr

(b) Address

658 N. Calver St

UG 16 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1411 Edmoreon Ave

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-15-1943 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-1943 to 8-15-1943.

and that I last saw her alive on 8-15-1943

Immediate cause of death

Cerebral hemorrhage

Duration

2 days

Due to Hypertension & arteriosclerosis

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Frank A. Saunders

M. D.

Address

1027 N. State St

Date signed 8-16-43

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0.0

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Stanislaw James Polonski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Frances Polonski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/2/1909

8. AGE: Years

42

Months

9

Days

13

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

12. Name

Hyungla Polonski

13. Birthplace

Poland

14. Maiden Name

Pauline

15. Birthplace

Poland

16 (a) Informant

Records

(b) Address

Johns Hopkins Hosp.

17 (a)

Burial

(b) Date thereof Aug 15 1943

(c) Cemetery or crematory

Holy Family

Location

Baltimore

18 (a) Funeral director

Fred W. Orazowski

19 (a)

(Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c)

City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2109 Bond St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1943 at 4:50 P

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

occlusion

Coronary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed August 16, 1943

Medical Examiner.

407289
G 07289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

163B 407289

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1007 E. Lombard St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

AMELIA PASTORE

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *May 9 1924*

8. AGE: Years Months Days If less than one day

19

3

5

hr. min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation *?*

11. Industry or business

FATHER

12. Name *Frank Pastore*

13. Birthplace *Italy*

MOTHER

14. Maiden Name *Mary Garofalo*

15. Birthplace *Baltimore Md.*

16 (a) Informant *Rose Giammona*

(b) Address *1009 E. Lombard St.*

17 (a) *Burial* (b) Date thereof *Aug. 18/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer Cem.*

Location *Belair Rd. Baltimore Md.*

18 (a) Funeral director *Frank Della Moe*

(b) Address *52 N. Morley St.*

AUG 16 1943 (b) *Huntington Williams M.D.*

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 14 1943* at *1:15* P.M.

21. I certify that I took charge of the remains described above, held an *inspection* thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *her* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Phenobarbital Poisoning

Due to

Other Conditions *Status epilepticus*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *8-14-43* M.

(b) Where did injury occur? *at home*

(c) Did injury occur at home, on farm, industrial place, in public place? *home* While at work?

(d) Means of injury *phenobarbital*

23. Signature *H. Z. Wollenweber* M.D.

Date signed *8-14-43*

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 302 S. Exeter St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 302 S. Exeter St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Alfonso Rossi

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Mary Rossi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1864

8. AGE: Years Months Days If less than one day

78

10

20

hr.

min.

9. Birthplace Montenapoli Domo Italy

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Pietro Rossi

13. Birthplace Italy

MOTHER

14. Maiden Name Domitilla Lamellia

15. Birthplace Italy

16 (a) Informant Mary Rossi (Wife)

(b) Address 302 S. Exeter St.

17 (a) Burial (b) Date thereof Aug. 18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location German Hill Rd. Baltimore Md.

18 (a) Funeral director Frank Della Hae

(b) Address 52 N. Morley St.

AUG 18 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1943 all day

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 1933 to 8-14-1943
and that I last saw him alive on 8/14 1943.

Immediate cause of death

arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams, M.D. Address 1901 Euterio Pl. Date signed 8/16/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07291
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3203 FOSTER AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3203 FOSTER AVE.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MARGARET M. DOERFLER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife JOHN G. DOERFLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 27 1860

8. AGE: Years Months Days If less than one day

83

0

17

16

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name GEORGE MAIER

13. Birthplace GERMANY

14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant ANNA J. DOERFLER (DAUGHTER)

(b) Address 3203 FOSTER AVE.

17 (a) BURIAL (b) Date thereof AUG. 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler, INC.

(b) Address 403 S. WOLFE ST.

AUG 16 1943

VB 124

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH AUG. 13 1943, at 6/15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1943 to Aug 13 1943, and that I last saw her alive on Aug 13 1943.

Immediate cause of death

Diabetes mellitus
Myocardial
Due to Carcinoma
July 25

Duration

1941

1941

1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm J. Hechtman

M. D.

Address 355 S. 1st St. Date signed

Aug 16-43

G 07292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07292

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

AUG 17 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Date signed

Medical Examiner.

07293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07293

106a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3728 Leo St, Brooklyn
(If rural give location)

(e) If foreign born, how long in U. S. A. 2 years

3 (a) FULL NAME

HUTSON, PAUL DEAN

3 (b) If veteran, name war

3 (c) Social Security Account

No. 11-1111

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1941

8. AGE: Years Months Days If less than one day
1 11 23 hr. min.9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

12. Name OTIS HUTSON

13. Birthplace Illinois

14. Maiden Name GRACY LAMB DIN

15. Birthplace Kentucky

16 (a) Informant Hospital records

(b) Address

17 (a) Removal (b) Date thereof 8/17/43
(month) (day) (year)

(c) Cemetery or crematory Pruden

Location Pruden Middleboro, Kentucky

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

AUG 17 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1943. 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1943. to 8-16 1943 and that I last saw him alive on 8-16 1943.

Immediate cause of death

respiratory failure

Due to ACUTE LARYNGOTRACHEO-BRONCHITIS

Due to hemolytic streptococcus hemolytic staphylococcus aureus

Other Conditions

mongolian idiocy
(Include pregnancy within 3 months of death)

Major findings:

Of operations tracheotomy - same

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith

Address Sydenham Hospital Date signed 8-16-43

Duration

2 1/2 hrs

11 hr

PHYSICIAN

Underline the cause to which death should be charged statistically.

07294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07294
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Married

6 (b) Name of husband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years Months Days If less than one day

56 2 10 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend

ed deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Source: Within 5 years of death. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07295
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution:

Monument & Rutland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Abraham Krakower

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Widower6 (b) Name of husband or wife Late Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 20, 1880

8. AGE: Years

63

Months

4

Days

26

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Clothing BusinessFATHER
MOTHER12. Name Gadala Krakower

13. Birthplace

Poland

14. Maiden Name

Gittle Fisher

15. Birthplace

Poland16 (a) Informant David Krakower(b) Address 4037 Fairfax Road17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof August 17,

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Washington RoadLocation Lansdowne Md18 (a) Funeral director Sol Levinson & Bros(b) Address 1124 1126 W North Ave

19 (a)

AUG 17 1943

(b)

Huntington Hall

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4037 Fairfax Road

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/1519 43 at 3 PM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/11 19 42 to 8/15 19 43and that I last saw him alive on 8/15 19 43Immediate cause of death Pulmonary edema

Duration

Due to

Heart

Due to

Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. H. Hall

Address

Sinai Hospital

Date signed

M. D.

8/15/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07296
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
one hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 16 1943

18 (a) Funeral director

(b) Address

19

AUG 17 1943

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-12-1943 at 3 A. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8-11-1943, to 8-12-1943,
and that I last saw him alive on 8-14-1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

7297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07297

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1725 N. Broadway

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1725 N. Broadway
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JULIUS G. BUNNECKE

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Ida A. Bunnecke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1869

8. AGE: Years Months Days If less than one day
73 10 15 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Contractor and Builder

11. Industry or business retired 20 years

12. Name John George Bunnecke

13. Birthplace Germany

14. Maiden Name Anna M. J. Cordes

15. Birthplace Germany

16 (a) Informant Mrs. Ida Bunnecke

(b) Address 1725 N. Broadway

17 (a) Burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

AUG 17-1943

(Date rec'd by registrar)

Baltimore, Md.
J. Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1943, at 8:45 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 5/31/1943 to 8/14/1943.
and that I last saw him alive on 8/13/1943.

Immediate cause of death

Cardio-renal - vascular
disease

Duration

5/21/43

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George A. Barker
Address 1517 E. North Ave. Date signed 8/16/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07298

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 102 W. 25th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 102 W. 25th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN VERNON FORREST

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 710-09-5956

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Lurline W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1884

8. AGE: Years

59

Months

6

Days

29

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation C. P. A.

11. Industry or business Union Trust Co.

12. Name John W. Forrest

13. Birthplace Va.

14. Maiden Name Emma Brown

15. Birthplace Baltimore

16 (a) Informant Mrs. Lurline W. Forrest

(b) Address 102 W. 25th St.

17 (a) Burial (b) Date thereof 8/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 17 1943

(Date and by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1943 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1943 to 8/14 1943 and that I last saw him alive on 8/2/43 1943.

Immediate cause of death

Carcinoma of bladder

Due to

Duration

Several months

Due to

Other Conditions General

Carcinomatous

(Include pregnancy within 3 months of death)

Date of operation May 1943

Major findings of operation Carcinomatous of bladder

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John F. Hogan

Address 7 E. Preston St. Date signed 8/16/43

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07299

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 513 N. Monroe St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
 (e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

3 (a) FULL NAME FRANK HELGERT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie E. Helgert.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1881

8. AGE: Years 62 Months 3 Days 8 If less than one day hr. min.

9. Birthplace Austria.
(Town, county, and state)10. Usual Occupation Tailor.11. Industry or business Cleaning & Dyeing Business12. Name Unknown13. Birthplace Austria.14. Maiden Name Unknown15. Birthplace Austria.16 (a) Informant Mrs. Marie E. Helgert.16 (b) Address 513 N. Monroe St.17 (a) Burial. (b) Date thereof 8/18/43.
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeem. Cem.Location Baltimore, Md.18 (a) Funeral director Charles J. Schwalb.(b) Address 505 N. Monroe St.

19 (a) (b)

20 (a) (b)

21 (a) (b)

22 (a) (b)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 513 N. Monroe St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August, -14-, 1943. 1030 P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 Aug 14, 1943 and that I last saw him alive Aug 14, 1943

Immediate cause of death

Acute dilatationof heart.Due to coronarythrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Shorb806 2 1/2 Fulton St. Aug 16, 43

Address Date

Duration

longoneyear

PLEASE WRITE PRINTED, with one exception, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 17 1943

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07300

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4013 Liberty High Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

3 (a) FULL NAME

Ignatz N. Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Régina Klein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1892

8. AGE:

Years

Months

Days

If less than one day

71

hr.

min.

9. Birthplace

Hungary

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Wolfe Klein

13. Birthplace

Hungary

14. Maiden Name

Frieda Kattel

15. Birthplace

Hungary

16 (a) Informant

Wm. Morris Shaver

(b) Address

2319 N. York St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8-17-43

(c) Cemetery or crematory

Hebrew Friendship

Location

18 (a) Funeral director

Jos. Reinecke

(b) Address

193 E. South St.

19 (a)

(b)

CHIEF OF BURIAL

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind.

(b) County

(c) City or town

Buch.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2765 W. North Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 16 1943 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 43 to Aug. 16 1943, and that I last saw him alive on Aug. 15 1943.

Immediate cause of death

Coronary failure.

Duration

Due to

Arteriosclerosis

Due to

Parasitic disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

W.B. Needle

23. Signature

Address 2314 - W. North Ave

Date signed 8/16/43

G 07301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1787 G 07301
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

FANNIE MAE FRASER

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-14-4156

4. Sex

F

5. Color of face

Caucasian

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 29 1917

8. AGE:

Years

Months

Days

If less than one day

25

8

15

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Piano Room

11. Industry or business

FATHER
MOTHER

12. Name

John F. Royer

13. Birthplace

Maryland

14. Maiden Name

Mary Onley

15. Birthplace

Maryland

16 (a) Informant

Mary Colbert

(b) Address

733 School St.

17 (a)

Burial

(b) Date thereof

8/18/43

(c) Cemetery or crematory

Mt Auburn

Location

Md

18 (a) Funeral director

Hess & Kelson

(b) Address

433 Plessman St

19 (a) AUG 17 1943

(Date rec'd by registrar)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 14 1943 at 8:40 PM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pulmonary edema

Due to

Inert gas

Other Conditions

(Include pregnancy within 9 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

8-14-43 5:30 PM

(b) Where did injury occur?

5400 Eastern Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? industrial While at work? yes

(d) Means of injury

Combustion of gas

23. Signature

J. L. Wallenmeyer

Date signed

8-15-43

Medical Examiner.

JWS

G 07303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07303
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date)

AUG 17 1943

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1943, to Aug 19 1943, and that I last saw him alive on Aug 19 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Date signed

M. D.

8/11

43

LEGIBLE WHILE FILING, WITH CORRECTING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07304
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2826 N Calverton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 17 1943

VS 3

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 14 -

1943 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 - 1943 to Aug 14, 1943, and that I last saw him alive on Aug 14, 1943.

Immediate cause of death

Carcinoma of Kidney

Duration

1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Chas. J. Keller

M. D.

Address

222 N. Monument

Date signed

Aug 16 - 43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07305
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Naomi Oliver

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Female Negro

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
13 Ind. hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John Oliver

13. Birthplace

Ind.

14. Maiden Name

Naomi Bundy

15. Birthplace

Ind.

16 (a) Informant

Records -

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof 8-18-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Whitman M. B. R.

Location

Baltimore, Md.

18 (a) Funeral director

Mrs. Suzanne A. Heynder

(b) Address

578 W. 1st St.

19 (a) AUG 17 1943

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 750 Hopkins Pl.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 15, 1943 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1943 to Aug 15, 1943 and that I last saw her alive on Aug 15, 1943

Immediate cause of death

Cerebral failure

Due to

The meningitis
Military, etc.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Helen Bowie

Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE FAIRLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07306
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2630 Flora St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Blarance Perry

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced

Married

6 (b) Name of husband or wife Clara Adelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1894

8. AGE: Years Months Days If less than one day

48 9 11 17 hr. min.

9. Birthplace Columbus, Ga.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Henry Perry

13. Birthplace Columbus, Ga.

14. Maiden Name Betty Jones

15. Birthplace Columbus, Ga.

16 (a) Informant Clara Adelle Perry

(b) Address 2630 Flora St.

17 (a) Burial (b) Date thereof Aug. 18, 1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium Baltimore Nat'l Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Halland

(b) Address 1414 N. E. St.

19 AUG 17 1945 (b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1945, at 2:45 M

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, inspection or inquiryby said Autopsy, inspection or inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

occlusion

Coronary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Featon M.D.

Medical Examiner.

Date signed August 14, 1945

G 07307 MJ-82698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07307
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 331 Hoffman St.

(If rural give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME

Essie Mae Cozart

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Clayborne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years Months Days If less than one day
46 ? ? hr. min.

9. Birthplace Georgia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George Thompson

13. Birthplace Georgia

14. Maiden Name Emma

15. Birthplace Georgia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Aug 17, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. ...

19 AUG 17 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1943

21. I certify that death occurred on the date above stated; that I attended
deceased from 7-17 1943 to 8-13 1943
and that I last saw him alive on 8-13 1943

Immediate cause of death

Peri-natal Abscess

Anemia

Due to Nephritis

Pulmonary embolus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-10-43

Major findings of operation: Cystocele
Femur

of autopsy: None

Duration

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PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Mrs. and Dr. ...

Address Baltimore City Date signed 8-16-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07308
Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 42 S. Stockton
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 18
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 42 S. Stockton
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Lillian Fisher
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4 Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Widowed
 6 (b) Name of husband or wife John Fisher
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1893

8. AGE: Years 49 Months 8 Days 22 If less than one day hr. min.

9. Birthplace Baltimore
 (Town, county, and state)

10. Usual Occupation House Work
 11. Industry or business

12. Name Joseph Thomas

13. Birthplace Balto

14. Maiden Name Elena Thompson

15. Birthplace Plymouth Md

16 (a) Informant Irene Brooks
 (b) Address 43 S. Stockton St

17 (a) Burial (b) Date thereof Aug 17, 1943
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
 Location

18 (a) Funeral director Mr. Kate R. Williams
 (b) Address 322 N. Schuman St

19 (a) Aug 17 1943 (b) Washington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1943 1:42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1943 to Aug 13 1943 and that I last saw her alive on Aug 13 1943

Immediate cause of death Cerebral Hemorrhage Duration

Due to Hypertensive Cardiac

Vascular Anal

Basic Coronary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. F. Howell

Address 601 N. Carrollton Ave Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07309
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 23 N. Bruce St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Durrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1943

8. AGE: Years Months Days If less than one day

4 mos

3

hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Robert Durrey

13. Birthplace Balto. Md.

14. Maiden Name Elsie Johnson

15. Birthplace Md.

16 (a) Informant Elsie Durrey

(b) Address 23 N. Bruce St

17 (a) Burial (b) Date thereof Aug 17-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 922 N. Schroeder St

AUG 17 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1943 at 2:30 P

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Interstital pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Guterma M.D.

Medical Examiner.

Date signed August 16, 1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07310

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1214 N. Carlton St
(If rural, give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

ROSE

MCCONKEY

3 (b) If veteran, name war

3 (c) Social Security Account

No. 219-166249

4. Sex

F

5. Color or race

Cie

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1915

8. AGE: Years Months Days If less than one day

28

29

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

William, McConey

13. Birthplace

Balto. Md.

14. Maiden Name

Rose Murray

15. Birthplace

Balto. Md.

16 (a) Informant

Isabelle Hall

(b) Address

1214 N. Carlton St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 19, 1943

(c) Cemetery or crematory

Mt. Auburn

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Schroeder St

AUG 17 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1943 at 1:00

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of back

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-15-43 at 1:00 18/2(b) Where did injury occur? 211 N. Ashington St

(c) Did injury occur at home, on farm, industrial place, in public

place? public While at work?(d) Means of injury Revolver - shot by23. Signature J. J. Wallenwicker M.D.Date signed 8-15-43 stray bullet

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07311
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 904 Russell St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME SARAH ETTA SKINNER LEE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Cul

6 (a) Single, married, widowed, or
divorced.6 (b) Name of husband or wife John Henry Lee

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1917

8. AGE: Years

26

Months

Days

If less than one day

hr.

min.

9. Birthplace Richmond - Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Skinner13. Birthplace Easton - N.C.14. Maiden Name Sarah Bullard15. Birthplace Henrico - Va.16 (a) Informant Miss Caroline Randolph(b) Address 904 Russell St.17 (a) Shipped (b) Date thereof Aug 17, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Richmond, Va

Location

18 (a) Funeral director Mrs. Katie R. Williams(b) Address 3218 S. Howard St19 (a) AUG 17 1943 (b) William Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1943 at 8:30 PM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pulmonary edemaDue to War gas, instant

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following: War gas 26/5(a) Date of injury 8-14-43 5:30 PM(b) Where did injury occur? 5800 Eastern Ave(c) Did injury occur at home, on farm, industrial place, in public
place? industrial While at work? yes(d) Means of injury Combustion of war gas23. Signature H. Z. Wallamater M.D.Date signed 8-15-43 Int. Medical Examiner.

Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

07312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07312

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1710 Vine St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1710 Vine St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amos Butler

3 (b) If veteran, name war

3 (c) Social Security Account
No. 212-16-2012

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Fannie Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE:

Years

Months

Days

If less than one day

60

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Chaffin

11. Industry or business

Tranfer

12. Name D. F. Butler

13. Birthplace Balto.

14. Maiden Name Fannie Marcell

15. Birthplace Calvert Co. Md

16 (a) Informant Fred Butler

(b) Address 210 N. Bruce St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 H 43

(c) Cemetery or crematory Mt. Calvary

Location Balto.

18 (a) Funeral director Balto B. Song &

(b) Address 139 W. Hamilton St.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th 1943 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1943 to 8/15 1943, and that I last saw him alive on 8/14 1943.

Immediate cause of death Hypertension
Type II heart disease

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Evan A. Siller

Address 60 N. Calhoun St Date signed 8/17/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

07313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07313
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 675 W. Pierce St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

LLOYD VENABLE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1907

8. AGE:

Years

Months

Days

If less than one day

35

10

19

hr.

min.

9. Birthplace Wottoway Co. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Woodson Venable13. Birthplace Blackstone, Va.14. Maiden Name Jane Fitzgerald15. Birthplace Wottoway Co., Va.16 (a) Informant Jane Venable(b) Address 916 N. 2nd St.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

8-19-43
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 17 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1943 at 11:35 P.M. M

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
 Autopsy, Inspection or Inquiry
 by said Autopsy, Inspection or Inquiry, find that said deceased came
 to his death on the day stated above, and death in my
 opinion resulted from: natural causes ☐ accident ☒ suicide ☐
 homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 8-15-4311:35 P.M.(b) Where did injury occur? Mulberry & Pine St.(c) Did injury occur at home, on farm, industrial place, in public
place? Public Place While at work? No(d) Means of injury Pedestrian struck by auto car.

23. Signature

J. H. Wallamacher

M.D.

Date signed

8-17-43

07314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07314

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1725 Edmondson Rd

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

Catherine Beverly

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

Edmondson

6 (c) If alive, give age

years

7. Birth date of deceased (yrs., day, mo.)

8. AGE: Years Months Days

If less than one day

hr. min.

9. Birthplace

(Town, county, and state)

Baltimore, Md

10. Usual Occupation

11. Industry or business

12. Name

Harrison Beverly

13. Birthplace

Va

14. Maiden Name

Pearl Williams

15. Birthplace

Va

16 (a) Informant

Harrison Beverly

(b) Address

1725 Edmondson Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8/17/43

(c) Cemetery or crematory

not known

Location

18 (a) Funeral director

(b) Address

6007 E. Canton Ave

(Date rec'd by registrar)

AUG 17 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-16

1943, at

2:05 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

8/16

1943, to

8/16

1943,

and that I last saw h

alive on

19

Immediate cause of death

Erythroblastosis

fetalis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Visceral hemorrhage

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

While at work?

(e) Means of injury

Signature

Address

Date signed

8-16-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07315

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1448 Patapsco St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 607 W. Cross St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Katherine Maymbe

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorcedDivorced

6 (b) Name of husband or wife

6 (c) If alive, give age 2 years7. Birth date of deceased (mo., day, yr.) Feb. 7, 18698. AGE: Years 74 Months 7 Days 3
If less than one day
hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation At home

11. Industry or business

12. Name William Holtgreve13. Birthplace Germany14. Maiden Name Anna (?)15. Birthplace Germany16 (a) Informant Harry E. Lambright(b) Address 1448 Patapsco St. (Nephew)17 (a) Burial (b) Date thereof Aug. 19, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Landon Park Cem.Location Baltimore, Md.18 (a) Funeral director H. Howard Evans(b) Address 1400 E. S. Charles St.19 (a) 17-1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1943 at 3:40 P.21. I certify that death occurred on the date above stated; that I attended
deceased from June 17, 1943, to Aug. 16, 1943.
and that I last saw her alive on Aug. 15, 1943.

Immediate cause of death

Coronary ThrombosisDue to Hypertensive Cardis-
vascular DiseaseDue to ArteriosclerosisOther Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. H. BaylerAddress 1600 Wilkens Ave Date signed 8/16/43 M. D.

Duration

4 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07316

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Pronounced dead at

(c) Hospital or institution:

St. Agnus Hospital (8-17-43)

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State N. J. (b) County Essex

(c) City or town East Orange

(If outside city or town limits, write RURAL and give town)

(d) Street No. 60 Warrington Place

(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country.

3 (a) FULL NAME

CARL HENRY AMON

3 (b) If veteran, name war

Yes

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Christina V. Amon

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 12, 1892

8. AGE: Years 51 Months 4 Days 5 If less than one day hr. min.

9. Birthplace New York City

(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Willys-Overland Company

12. Name Charles A. Amon

13. Birthplace Germany

14. Maiden Name Mary Rasp

15. Birthplace U. S. A.

16 (a) Informant Mrs. Carl H. Amon (Wife)

(b) Address 60 Warrington Place, Orange, N. J.

17 (a) Burial (b) Date thereof 8/10/1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wiltwyck Cemetery

Location Kingston, New York.

18 (a) Funeral director Stewart & MOWan Company

(b) Address 108 W. North Av. (W. F. Wooden-Suc.)

AUG 17 1943
(Date rec'd by Registrar) Hunterton Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1943 at 12:30 PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence

obtained by said find that said deceased came to his death on the day stated above.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other Conditions No

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Z. Wallenweber M.D.

Date signed 9-17-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

296194 07317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07317
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JONES HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State D. C. (b) County

(c) City or town Washington

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3655 Suitland Rd. S.E.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Gaspar and R. Thiebault

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Delia

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1-6-90

8. AGE:

Years

Months

Days

If less than one day

53

7

11

hr.

min.

9. Birthplace

Minn.

(Town, county, and state)

10. Usual Occupation

Engraver

11. Industry or business

FATHER

12. Name Benoni Thiebault

13. Birthplace

Canada

14. Maiden Name Anaislasia Ryland

15. Birthplace

Canada

16 (a) Informant

Records

(b) Address

JONES HOPKINS HOSPITAL

17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

Aug 17, 1943

(c) Cemetery or crematory

Location

North DC

18 (a) Funeral director

(b) Address

James T. Ryan, Jr.
317 - Pa Ave SE

19. Read by registrar

Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17, 1943, 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1943 to 8-17 1943.

and that I last saw him alive on 8-17 1943.

Immediate cause of death Cerebral Ischemia, toxemia.

Duration

12 hrs

Due to

Peripheral circulatory failure

12 hrs

Due to

Hypoproteinemia by Cirrhosis of liver

8 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8-12-43

Major findings of operation:

Cirrhosis of liver.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John H. Kehne

Address

Johns Hopkins Hosp

Date signed 8-17-43

G 07318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07318
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 8 N. Linwood Ave.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 8 N. Linwood Ave
(If rural, give location)
- (e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Katherine Feldmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEM

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Henry H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 18, 1869

8. AGE: Years Months Days If less than one day

74527hr.min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

FATHER
MOTHER12. Name William Schrieber13. Birthplace Germany14. Maiden Name Louise Seibert15. Birthplace Baltimore Md.16 (a) Informant Henry H. Feldmann(b) Address 8 N. Linwood Ave.17 (a) BURIAL (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory BALTIMORE
Location E. NORTH AVE18 (a) Funeral director CLARENCE F. HOFFMANN(b) Address 1639 N. BROADWAY19 (a) (b)
(Date rec'd by registrar) Registrar

AUG 17 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1943, at 7:45 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1930 to Aug 14, 1943, and that I last saw her alive on Aug 1, 1943

Immediate cause of death

Coronary Thrombosis

Duration

1 1/2 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
- (Specify type of place)

(e) Means of injury Louis Kraus23. Signature Louis KrausAddress 1639 N. BROADWAYDate signed 8/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully spelled and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07319
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 2566 W. Fairmount Ave.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2566 W. Fairmount Ave.
(If rural give location)
- (e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Leonard B. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Eva. V. Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1870

8. AGE: Years Months Days If less than one day

72727hr.min.9. Birthplace Atlanta Ga.

(Town, county, and state)

10. Usual Occupation Stationary Engineer

11. Industry or business

12. Name William13. Birthplace Atlanta Ga.14. Maiden Name not known15. Birthplace Atlanta Ga.16 (a) Informant Eva. V. Hayes(b) Address 2566 W. Fairmount Ave.17 (a) BURIAL (b) Date thereof 8/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRALLocation OLD FREDRICK R.R.18 (a) Funeral director CLARENCE F. HOFFMANN(b) Address 1639 N. BROADWAY19 (a) Aug 17 1943

(Date read by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14th 1943 at 10:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from August 13 1943 to August 14 1943, and that I last saw him alive on August 14 1943

Immediate cause of death

Cerebral hemorrhage

Due to Hypertensive and arterio
sclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thos. E. Roach3629 Edmondson Ave. Date signed 8/15/43Thos. E. ROACH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07320
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1123 E. Lexington St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret

Barnes

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or
divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7 / 22

8. AGE: Years Months Days If less than one day

21 6 6 hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Andrew Barnes

13. Birthplace Richmond Va.

14. Maiden Name Bettie Mason

15. Birthplace Richmond Va.

16 (a) Informant Andrew Barnes

(b) Address 1602 E. Pratt St.

17 (a) Burial (b) Date thereof Aug 17
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Q.A. County Md

18 (a) Funeral director Mrs. Beat A. Ellard & Dpt

(b) Address 1129 N. Caroline St.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1943, at 12 Noon M

21. I certify that I took charge of the remains described above, held an

Impression thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar

pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed August 13 1943

G 07321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4009 Leold Spring Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 85

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

John A. Miller

b (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31/1858

8. AGE: Years 85 Months 16 Days 16 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address 4009 Leold Spring Lane

17 (a) Burial, cremation, or removal

(b) Date thereof Aug 19, 1943
(month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(Date)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1943 at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 30 1941, to Aug. 16 1943, and that I last saw him alive on Aug. 15 1943

Immediate cause of death

Chr. Myocarditis

Due to

Chr. Interstitial Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1663 W. York Ave.

Date signed 8/16/43

Duration

1943

1940

PHYSICIAN

Underline the cause to which death should be charged statistically.

64-39944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07322

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State OREGON (b) County

(c) City or town PORTLAND

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2304 NE MULTNOMAH

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Robert Gillmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-88

8. AGE: Years 55 Months 6 Days - If less than one day hr. min.

9. Birthplace

MASS

(Town, county, and state)

10. Usual Occupation

MARINE ENGINEER

11. Industry or business

12. Name THOMAS GILLMORE

13. Birthplace ENG

14. Maiden Name AMELIA MATHESON

15. Birthplace MASS

16 (a) Informant RECORDS

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof Aug 17/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or cremation location

3501 Broadway Ave.

18 (a) Funeral director

John Mitchell Jones

19 (a) (Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1943, at 555A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943, to Aug 14 1943, and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Coronary occlusion

Due to arteriosclerosis

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

Immediate

Years

Years

Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George Bunch

Address John Hopkins Date signed 8-17-43

G 07323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07323

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 00.0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3809 Clifton Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

ALLAN

JOHANNES

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-03-0911

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1885

8. AGE:

Years

Months

Days

If less than one day

58

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

R.F. Lemley Co.

FATHER

12. Name

Allen Johannes

13. Birthplace

Md.

MOTHER

14. Maiden Name

Sara Mitchell

15. Birthplace

Balto. Md.

16 (a) Informant

Mrs. Eleanor M. Johannes

(b) Address

3809 Clifton Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

8/19/49
(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

J. J. Johnson

(b) Address

North & Penna Ave

AUG 17 1949

(b)

J. J. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16, 1949 at 20-M

21. I certify that I took charge of the remains described above, held an

inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature M. J. Wallenwachen M.D.

Certified Examiner.

Date signed 8-17-49

G 07324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07324

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5115 Eastern Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 5115 Eastern Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Martin Paul Wischhusen

3 (b) If veteran, name war
NO3 (c) Social Security Account
No. None4. Sex
M5. Color or race
W6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1910

8. AGE: Years 32 Months 8 Days 4
If less than one day hr. min.9. Birthplace Baltimore (Gwynnbrook) Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name John Wischhusen

13. Birthplace Maryland

14. Maiden Name Lurene C. Vetter

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lurene C. Wischhusen

(b) Address 5115 Eastern Ave.

17 (a) Burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1943, 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 11 1943 to August 14 1943, and that I last saw him alive on 8/14 1943.

Immediate cause of death

Pulmonary Tbc.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 8/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS in

SM G 07325
83196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07325
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Aliceann St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

John Wm. Winslow

3 (b) If veteran, name war
No

3 (c) Social Security Account
No 215-18-7008

4. Sex
M

5. Color or race
W

6 (a) Single, married, widowed, or divorced.
Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1875

8. AGE: Years Months Days If less than one day
68 1 26 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name John Winslow

13. Birthplace Md.

14. Maiden Name Katherine Phillips

15. Birthplace Md.

16 (a) Informant Miss Kate Winslow

(b) Address 712 B. Linwood Ave.

17 (a) Burial (b) Date thereof 8/19/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 (a) AUG 17 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1943 at 12:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1943 to 8/16 1943 and that I last saw him alive on 8/16 1943

Immediate cause of death

Prob. S.I. malignancy
site unknown

Due to

Due to

Anemia, dehydration,
Other Conditions: autolysis,
menstrual changes

(Indicate conditions within 2 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B E. J. Surman

Address B E. J. Date signed 8/16

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07326
Registered No.**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 2819 Lake Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

(State rec'd by registrar)

VS 188

2. USUAL RESIDENCE OF DECEASED:(a) State MD (b) County Balti(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No 2819 Lake Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country**MEDICAL CERTIFICATION**20. DATE OF DEATH Aug. 18 1943 at 2:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Due to ArteriosclerosisDue to Myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Michael J. [Signature]Address 540 [Address] Date signed 8-18-43**PHYSICIAN**

Underline the cause to which death should be charged statistically.

G 07327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07327

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2828 Clifton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

life

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2828 Clifton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Mary E. Helm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

late Thomas B.

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

July 24, 1874

8. AGE: Years

64

Months

Days

20

If less than one day

hr.

min.

9. Birthplace

Maryland

(town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John J. Haynes

13. Birthplace

Maryland

14. Maiden Name

Mary L. Moore

15. Birthplace

Maryland

16 (a) Informant

Capt. Oscar J. Helm

(b) Address

2828 Clifton Ave.

17 (a) Burial

(b) Date thereof

Aug 18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balt., Md.

18 (a) Funeral director

Harry H. Witzke

(b) Address

4101 Edmondson Ave

AUG 17 1943

Huntington Williams, Md

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 14

1943 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14, 1941, to Aug 14, 1943, and that I last saw her alive on Aug 14, 1943.

Immediate cause of death

Pneumonia in C.V. - Rnd

Lung

Due to

Due to

Other Conditions

Pulmonary embolism

C. Pleural Effusion

(Include pregnancy within 3 months of death)

Date of operation

Jan 1943

Major findings of operations

Multiple

D. vertebrae

of autopsy

None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

C. J. Lubinski

Address

5212

Baltimore, Md signed 8/14/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07328

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 17 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/15 1943 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1943 to 8/15 1943 and that I last saw her alive on 8/15 1943.

Immediate cause of death

Shock

Due to

Possible cerebral embolism

Due to

Other Conditions

Empyema, left; left lobectomy; 8/14/43; Empyema (thoracotomy done)

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur out-home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address St Agnes Hospital Date signed 8/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07329

BALTIMORE CITY HEALTH DEPARTMENT

G 07329

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1908 EASTERN AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 YRS.

3 (a) FULL NAME

JOSEPHINE BUDZYNSKI

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife ANDREW BUDZYNSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10 1864

8. AGE: Years Months Days If less than one day

79

3

4

hr

min.

9. Birthplace

POLAND

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JOHN NOWAKOSOSKI

13. Birthplace POLAND

14. Maiden Name UNKNOWN

15. Birthplace POLAND

16 (a) Informant VERA MACK (DAUGHTER)

(b) Address 1908 EASTERN AVE.

17 (a) BURIAL (b) Date thereof AUG.

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory INDP. POLISH NATIONAL

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a)

AUG 17 1943

(b)

Intestine for William M. J.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1908 EASTERN AVE.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH AUG. 14 1943. at 7/50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Aug 14 1943. and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Coronary Ventricle

Duration

Aug 14

Due to

Due to

Arterio Sclerosis

1944

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

William J. R. Sauer

Date signed Aug 16 1943

M. D.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE IN INK
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07330		BALTIMORE CITY HEALTH DEPARTMENT		6 07330	
PLACE OF DEATH:		CERTIFICATE OF DEATH		131a Registered No.	
(a) Baltimore City, Maryland		2. USUAL RESIDENCE OF DECEASED:		(a) State MD. (b) County BALTO.	
(b) Street address 618 N. COLLINGTON AVE.		(c) City or town BALTIMORE		(If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution:		(d) Street No. 618 N. COLLINGTON AVE.		(If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country (Yes or No)		If yes, name country	
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS.		3 (a) FULL NAME		CASPER JOHN GUNZELMAN	
3 (b) If veteran, name war		3 (c) Social Security Account		No. NONE	
4. Sex MALE		5. Color or race WHITE		6 (a) Single, married, widowed, or divorced WIDOWER	
6 (b) Name of husband or wife ANNA GUNZELMAN		6 (c) If alive, give age		years	
7. Birth date of deceased (mo., day, yr.) APR. 18 1862		8. AGE: Years 81 Months 3 Days 29		If less than one day hr. min.	
9. Birthplace GERMANY		10. Usual Occupation RETIRED BUTCHER		11. Industry or business FOR SELF	
12. Name BALTASSAN GUNZELMAN		13. Birthplace GERMANY		14. Maiden Name UNKNOWN	
15. Birthplace GERMANY		16 (a) Informant GEORGE GUNZELMAN. (SON)		(b) Address 528 N. STREEPER ST.	
17 (a) BURIAL		(b) Date thereof AUG. 18/43		(month) (day) (year)	
(c) Cemetery or crematory HOLY REDEEMER		Location BELAIR ROAD		18 (a) Funeral director Lilly and Becker, Inc.	
(b) Address 403 S. WOLFE ST.		19 (a) AUG 17 1943		Registrar	
20. DATE OF DEATH AUG. 16 1943 at 12/50 AM.		21. I certify that death occurred on the date above stated; that I attended deceased from July 1930, to Aug 15 1943, and that I last saw him alive on Aug 15 1943.		Immediate cause of death Chronic myocarditis + Chronic Nephritis	
Due to		Due to		Other Conditions General arteriosclerosis	
Date of operation		Major findings of operation:		of autopsy:	
22. If death was due to external causes, fill in the following:		(a) Accident, suicide, or homicide		(b) Date of occurrence	
(c) Where did injury occur?		(City or town) (County) (State)		(d) Did injury occur about home, on farm, industrial place, in public place? While at work?	
(Specify type of place)		(e) Means of injury		23. Signature	
Address 2005 E. Monument St		Date signed 8/17/43		M. D.	

G 07331

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07331

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 3910 MT. PLEASANT AVE.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.
 (c) City or town BALTIMORE
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3910 MT. PLEASANT AVE.
 (If rural give location)
 (e) Citizen of foreign country (Yes or No)
 If yes, name country

3 (a) FULL NAME

MARGARET WALDHAUSER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 6 1875

8. AGE: Years Months Days If less than one day

68

6

9

hr

min

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

12. Name JOHN KEPPEL

13. Birthplace BALTO. MD.

14. Maiden Name UNKNOWN

15. Birthplace BALTO. MD.

16 (a) Informant MARGARET WALDHAUSER (DAUGH)

(b) Address 3910 MT. PLEASANT AVE.

17 (a) BURIAL (b) Date thereof AUG. 19/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lill and Miller, N.Y.C.

(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (Registrar)

VS AUG 17 1943

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH AUG. 15 1943 at 3/45M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1942 to Aug 15 1943, and that I last saw him alive on Aug 15 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

3 days

Due to Hypertension

Due to

Other Conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 142 East Ave Date signed 8/17/43

M. D.

Physician: Please write the causes of death clearly and legibly.

G 07332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07332

Registered No.

1. PLACE OF DEATH: St. Elizabeth's Convent

(a) Baltimore City, Maryland

(b) Street address 35 N. Lakewood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Fairmont Ave. Lakewood St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sister Mary Medarda (Mary Myers)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

77 5 14

If less than one day

hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1943 at 8¹⁵ A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1943 to Aug. 15 1943 and that I last saw her alive on Aug. 15 1943.

Immediate cause of death

CerebralHemorrhage

Duration

Due to

Due to

Other Conditions GeneralizedArteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? (Specify type of place)

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Lusting M.D.Address St. Joseph's Hosp. Date signed 8-15-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 17 1943

G 07333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07333

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4401 Liberty Heights

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4401 Liberty Heights

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

James W. Laidler, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 220-07-5912

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

Widowed

6 (b) Name of husband or wife Margaret A. Laidler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1880

8. AGE:

Years

Months

Days

If less than one day

63

2

24

hr.

min.

9. Birthplace

Georgia

(City, county, and state)

10. Usual Occupation

11. Industry or business

Equitable Trust

FATHER
MOTHER

12. Name

Solomon Laidler

13. Birthplace

U. S.

14. Maiden Name

Ella Turrentine

15. Birthplace

U. S.

16 (a) Informant

Mr. James Laidler, Jr.

(b) Address

4401 Liberty Heights

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug. 18, 1943

(c) Cemetery or crematory

Woodlawn Cemetery

Location

Woodlawn, Md.

18 (a) Funeral director

Ellis Lavoie

(b) Address

4510 Liberty Heights Ave.

19 (a)

(Date rec'd by registrar)

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 15, 1943, at 1:15 P

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed

August 16, 1943

Medical Examiner.

UG 17 1943

G 07334

ZIEMANN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V G 07334

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 607 S. East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs3 (a) FULL NAME Katherine Ziemann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or Chas. E. Ziemann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21-18618. AGE: Years 82 Months 5 Days 25 If less than one day hr. min.9. Birthplace Germany
(Town, county and state)10. Usual Occupation Housewife11. Industry or business At Home

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Joseph Turner(b) Address 607 S. East Ave.17 (a) Burial (b) Date thereof Aug-18-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Schuyler Cem.Location O'Donnell St Rd18 (a) Funeral director John S. Connolly(b) Address 708 Eastern Ave.

19 17 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 607 S. East Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-15th 1943, at M21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1943 to 8/10 1943, and that I last saw him alive on 8/14 1943.Immediate cause of death Coronary ThrombosisDue to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Chas. FlornAddress 3215 Eastern Ave.Date signed 8/17/43

Chas. Florn

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Underline the cause to which death should be charged statistically.

07335

439360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 07335
(m)

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Prince George

(c) City or town Laurel

(If outside city or town limits, write RURAL and give town)

(d) Street No. R 75

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emilia A. Harzer

3 (b) If veteran, name war

3 (c) Social Security Account

No.

None

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Karl H. Harzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-25-02

8. AGE:

Years

Months

Days

If less than one day

40

41

7

2

3

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Christopher Drayer

13. Birthplace

Germany

MOTHER

14. Maiden Name

Antonia Heinke

15. Birthplace

Germany

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

8-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Fort Hill FORT LINCOLN

Location

Laurel Md. PRINCE GEORGE COUNTY, MD.

18 (a) Funeral director

Hester & Houghton

AUG 18 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

35

20. DATE OF DEATH

August 17, 1943 at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1943, Aug. 17, 1943, and that I last saw him alive on Aug. 17, 1943.

Immediate cause of death

Pulmonary embolus

Duration

Due to

Pulmonary embolus

Due to

Other Conditions

Obesity

(Include pregnancy within 3 months of death)

Date of operation

8-13-43

Major findings of operation: Submucous

myoma

of autopsy: Pulmonary embolus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert B. Scott

Address

plus Hopkins Hosp

Date signed

8/17/43

G 07336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07336
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Louisa Berkowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

63

8

6

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Journeyman

11. Industry or business

Blacksmith

FATHER

12. Name John Berkowski

13. Birthplace

Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant

Elsa L. Clark

(b) Address

1727 E. Preator St

17 (a)

Burial

(b) Date thereof

8/18/43

(Burial, cremation, or reburial)

(month) (day) (year)

(c) Cemetery or crematory

St. Michaels Church

Location

Perry Hall Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 AUG 18 1943

(b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18, 1943, at 1:50 PM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 9 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Aug 18, 43

M.

(b) Where did injury occur?

Public

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Drowning

23. Signature

H. L. Wallamater M.D.

Medical Examiner

Date signed

9-15-43

07337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 7337

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3030 Guilford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3030 Guilford Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Edward E. Lattin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mary G. Lattin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 19th 1885

8. AGE: Years

Months

Days

If less than one day

57

11

28

hr.

min.

9. Birthplace

Conn

(Town, county, and state)

10. Usual Occupation

Elec. Engineer

11. Industry or business

C & P Tel Co

12. Name

Elliott O. Lattin

13. Birthplace

Conn

14. Maiden Name

Emily E. Ryther

15. Birthplace

Conn

16 (a) Informant

Mary Lattin

(b) Address

3030 Guilford Ave

17 (a)

Burial

(b) Date thereof

8/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge

Location

Pikesville, Md.

18 (a) Funeral director

William Cook, Inc.

(b) Address

1217 S. Paul St

AUG 18 1943

(Date rec'd by registrar)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17th 1943, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1943 to Aug 17 1943, and that I last saw him alive on Aug 17 1943.

Immediate cause of death

Chronic myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Elliott O. Lattin

Address

1735 Poplar St

Date signed

8/17/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. EVERY ITEM OF INFORMATION CONCERNING CAUSE OF DEATH IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSE OF DEATH CLEARLY AND LEGIBLY.

07338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07338
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Information

(b) Address

17 (a) Funeral

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 AUG 18 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1943 to Aug 17 1943, and that I last saw him alive on Aug 17 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

07339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07339

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 615 W. Conmy Street

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Irby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1943

8. AGE: Years

Months

Days

If less than one day

7 hr. 15 min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Alexander Irby

13. Birthplace

South Carolina

MOTHER

14. Maiden Name Myrtle Flamming

15. Birthplace

South Carolina

16 (a) Informant Hospital Records(b) Address Johns Hopkins Hospital

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL AUG 17 1943

18 (a) Funeral director

(b) Address

AUG 18 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1943, at 8:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1943, to August 1943, and that I last saw him alive on August 1 1943.

Immediate cause of death Atalectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Philip P. Heptag Jr.

M. D.

Address Johns Hopkins HospitalDate signed 8-4-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07340

439199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161b

G 07340
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **md.** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **1430 Belvedere ST.**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Ernest Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-31-43

8. AGE:

Years

Months

Days

7

If less than one day

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Charles Blackwell

13. Birthplace

md.

MOTHER

14. Maiden Name

Dolores ?

15. Birthplace

md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

JOHNS HOPKINS MEDICAL SCHOOL

Location

AUG 17 1943

18 (a) Funeral director

Thurston Williams, M.D.

AUG 18 1943

(Date rec'd by registrar)

Thurston Williams, M.D.

Registrar

VS 144

0297

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 7 1943** at **1 P. M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug. 5 1943** to **Aug. 7 1943** and that I last saw him alive on **Aug. 7 1943**

Immediate cause of death

Sepsis
Septicemia
Pneumonia

Due to

umbilical infection

Due to

Other Conditions **? Cong. Syphilis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. Z. Rendall

Address

John Hopkins Hosp.

Date signed **8/9/43**

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

07341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1572 Registered No. G 07341

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943 to Aug 6 1943 and that I last saw him alive on Aug 6 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 07342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07342
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 18 1943

VB 154

G 07343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07343

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3310 Fairfield Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3310 Fairfield Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

THELMA MALLOCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Cul

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 19438. AGE: Years Months Days If less than one day
4 24 hr. min.9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Dahis Jenkins13. Birthplace N.C.14. Maiden Name Edna Mallock15. Birthplace Balto. Md.16 (a) Informant Martin Mallock(b) Address 3310 Fairfield Rd.17 (a) Burial (b) Date thereof Aug 18, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt Zion Cem

Location

18 (a) Funeral director Mr. Kate R. Williams(b) Address 822 N. Ashcroft St19 (a) AUG 18 1943(Date rec'd by Registrar) Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1943 10:45

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Asphyxiation in bed clothes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-15-4325/6
M.(b) Where did injury occur? above address(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?(d) Means of injury smothering in bed clothes23. Signature H. L. Williams, M.D.

Medical Examiner.

Date signed 8-26-43

G 07344

Walter Gordon
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07344

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

less than one day

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from to and that I last saw deceased on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

In case of death, please write the causes of death clearly and legibly.

AUG 18 1943

G 07345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07345

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1011 Brantley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Aubrey Vernon Alexander

3 (b) If veteran, name war

3 (c) Social Security Account

No. 102-16-6626

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or

divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1922

8. AGE:

Years 19

Months 11

Days 15

If less than one day

hr. 13

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Lafayette Alexander

13. Birthplace Snow Hill Md.

14. Maiden Name Lillie Elmer

15. Birthplace Atlantic City, N. J.

16 (a) Informant Lillie Alexander

(b) Address 1011 Brantley Ave

17 (a) Burial (b) Date of death Aug 18, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. 1st

19 (a) (b) (Date rec'd by registrar) Registrar

AUG 18 1943 Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limit, write RURAL and give town)

(d) Street No. 1011 Brantley Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1943 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Aug 15 1943, and that I last saw him alive on Aug 14 1943.

Immediate cause of death

Pulmonary Tuberculosis

Duration

7

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. H. Stewart

Address 625 Schenck St.

Date signed 8/17/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07346

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1346 W Mosher St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1346 W Mosher St
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Sam Formane

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Married6 (b) Name of husband or wife Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 18 1890

8. AGE:

Years

Months

Days

If less than one day

581

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business Grocer StoreFATHER
MOTHER12. Name Chaim Forman13. Birthplace Russia14. Maiden Name Dora ?15. Birthplace Russia16 (a) Informant Pearl Forman(b) Address 1346 W Mosher St17 (a) Burial (b) Date thereof August 18, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road18 (a) Funeral director Sol Levinson & Bro(b) Address 1128 1126 W North Ave19 (a) (b)
(Date rec'd by registrar)AUG 18 1943

Registrar

Huntington Williams

MEDICAL CERTIFICATION

11

20. DATE OF DEATH August 17 1943 at P. M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 1942 to Aug 17, 1943
and that I last saw him alive on Aug 14, 1943

Immediate cause of death

Ca. of stomach

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James V. FrenkilAddress 1422 Park Ave Date signed 9/17/43

FRENKIL

G 07347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

G 07347

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.D.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 220-09-6749

4. Sex

m

5. Color or race

w.

6 (a) Single, married, widowed, or divorced:

DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR 7-1887

8. AGE:

56

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace BALTIMORE

(Town, county, and state)

10. Usual Occupation

CLERK

11. Industry or business

HOTEL

FATHER

12. Name WILLIAM M. JONES

13. Birthplace BALTIMORE

MOTHER

14. Maiden Name CLARA ADDISON

15. Birthplace BALTIMORE

16 (a) Informant HENRIETTA ROBINETTE TOWNSEND

(b) Address 2820 WINDSOR AVE

17 (a) BURIAL (b) Date thereof AUG 18-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory THE OLIVET

Location FREDERICK ROAD

18 (a) Funeral director CHAS. F. EVANS & SON

(b) Address 118 W. ME ROYAL AVE

19 AUG 18 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4 E Redwood St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1943, at 10:10 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to the death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Heart

Due to Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed 8/12/43 Medical Examiner.

07348

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07348

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caton & Wilkins Avenues*

(c) Hospital or institution:

Saint Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2*(e) Length of stay in Baltimore (yrs., mos., or days) *-*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *-*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *St Agnes Hospital*

(If rural give location)

(e) Citizen of foreign country? *no*

(Yes or No)

If yes, name country *37 Gorman Ave.*

3 (a) FULL NAME

*Baby Boy Close (WILLIAM HERBERT CLOSE)*3 (b) If veteran, name war *-*3 (c) Social Security Account No. *-*

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

*single*6 (b) Name of husband or wife *none*6 (c) If alive, give age years *-*

7. Birth date of deceased (mo., day, yr.)

8/15/43

8. AGE:

Years *-*Months *-*Days *1*

If less than one day

12 hr. 50 min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

baby

11. Industry or business

MOTHER / FATHER

12. Name

William Herbert Close

13. Birthplace

Baltimore, Maryland

14. Maiden Name

Mary Angela Gore

15. Birthplace

*Baltimore, Maryland*16 (a) Informant *William H. Close*(b) Address *37 Gorman avenue*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

18 (a) Funeral director

Chas. J. Evans, Inc.

(b) Address

112 N. Mt. Royal Ave.

19

AUG 18 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

*8/17*1943, at *2:05* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *8/15* 1943, to *8/17* 1943,and that I last saw him alive on *8/17* 1943.

Immediate cause of death

Congenital heart disease

Due to

Due to

Other Conditions

Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Howard W. Stein

Address

St Agnes Hospital

Date signed

8/17/43

G 07349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07349

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (c) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location

18 (a) Funeral director

(b) Address

19 AUG 18 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1943, at 1 A. M.

21. I certify that I took charge of the remains described above, held an Inquiring thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Systolic embolism
Pneumonia acute, left leg.

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wollenweber M.D.

Date signed 8-17-43 Medical Examiner

07350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07350

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

508 Asquith St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

life

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

508 Asquith

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Alberta Stewart Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Henry Murray

6 (c) If alive, give age

66 years

7. Birth date of deceased (mo., day, yr.)

Jan. 6th 1883

8. AGE:

Years

Months

Days

If less than one day

60

7

10

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Charles H. Johnson

13. Birthplace

Alexandria, Va.

14. Maiden Name

Alberta Johnson

15. Birthplace

Md.

16 (a) Informant

Henry Murray

16 (b) Address

508 Asquith St.

17 (a) Burial

Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 20th 1943

(c) Cemetery or crematory

Mt Calvary

Location

A. A. Co. Md.

18 (a) Funeral director

Baptist Minister W. Wright

(b) Address

723 Asquith St.

19 (a) Date rec'd by registrar

Aug 18 1943

(b) Signature

H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 16 1943 at 9:16 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

Aug 12 1943 to Aug 16 1943

and that I last saw him alive on Aug 16 1943

Immediate cause of death

Acute Cerebral Apoplexy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Dr. S. Allen

Address

121 Asquith St.

Date

Aug 17 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07351

JL - 54327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07351

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. 3-4-12
(yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 McElderry St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George Street

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1911

8. AGE: Years

31

Months

6

Days

16

If less than one day

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Stevedore

11. Industry or business

FATHER
MOTHER

12. Name George

13. Birthplace

Va.

14. Maiden Name Emma Watson

15. Birthplace

Va.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug. 17-1943
(month) (day) (year)

(c) Cemetery or crematory

Location Pleasant Rest
Dorson, Balto. Co., Md.

18 (a) Funeral director

B. C. H. Records

(b) Address

721 Algonquin St.

19 (a)

AUG 18 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1943, 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1940 to 8-14 1943 and that I last saw him alive on 8-14 1943.

Immediate cause of death

Pulmonary Tuberculosis

Duration

10 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul H. H. H.

M. D.

Address

B. C. H.

Date signed 8-16-43

G 07352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07352

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Wilkes & Caten*

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Balt*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *204 S. Hilton St.* (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Raymond Watson

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. *none*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *MAY 18 - 1890*

8. AGE: Years Months Days If less than one day

53 4 28 hr. min.9. Birthplace *Balt*

(Town, county, and state)

10. Usual Occupation *Letter Carrier*

11. Industry or business

12. Name *Joseph*13. Birthplace *Balt*14. Maiden Name *Ann*15. Birthplace *Balt*16 (a) Informant *Edna Watson Eberle*(b) Address *606 Plymouth Rd*17 (a) *Burial* (b) Date thereof *Aug 19 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. National Cemetery*Location *Baltimore Md*18 (a) Funeral director *Frank H. Seitz*(b) Address *814 N 36 St*19 (a) *AUG 18 1943* (b)20. DATE OF DEATH *8/16* 19*43* at *1:45 PM*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *8/14* 19*43* to *8/16* 19*43*,and that I last saw him alive on *8/16* 19*43*.

Immediate cause of death

Bronchial Pneumonia

Due to

Acute Catarrhal Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *W. J. Bryson*Address *St Agnes Hosp* Date signed *8/16/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED BY THE BALTIMORE CITY HEALTH DEPARTMENT AUG 18 1943

G 07353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07353

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 16, 1943, at 12:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19, 1943, to Aug. 16, 1943, and that I last saw her alive on Aug. 16, 1943.

Immediate cause of death

Bronchiectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Lusting

Address

St. Joseph's Hosp

Date signed

8-16-43

AUG 18 1943

William H. Lusting, M.D.

07354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07354

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 002

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 753 W. Lexington

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

BERTHA

BORY ST.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-22-6826

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Frank C. Bory

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1881

8. AGE:

Years

Months

Days

If less than one day

62

3

1

hr.

min.

9. Birthplace

Baltimore, Co. Md

(Town, county, and state)

10. Usual Occupation

House keeper

11. Industry or business

FATHER
MOTHER12. Name Thomas Killen13. Birthplace Baltimore Co. Md14. Maiden Name Catherine Dailey15. Birthplace Baltimore Co. Md16 (a) Informant Elizabeth Chaney(b) Address North Rolling Rd. Catonsville17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 20, 1943

(month) (day) (year)

(c) Cemetery or crematory New CathedralLocation Baltimore, Md18 (a) Funeral director Desmond S. Carrington(b) Address 21 W. 25th St.19 (a) AUG 18 1943(b) Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1943, at 8:30 PM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia, lobular

Due to

Abscess, tubo-ovarian
leftOther Conditions his

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death will in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature H. Z. Wallenwaber M.D.

Medical Examiner.

Date signed 8-17-43

AB-12121 G 07355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07355

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Avenue**
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7 Yrs.-6 Mos.-13 Days**

(e) Length of stay in Baltimore (yrs., mos., or days) **27 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County _____
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **226 Patterson Park Ave.**
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Carrie Bryant.

3 (b) If veteran, name war _____

3 (c) Social Security Account
No. _____4. Sex
F5. Color or race
W6 (a) Single, married, widowed, or
divorced. **Single**

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) **April 10 1875**8. AGE: Years **68** Months **4** Days **7**
If less than one day _____ hr. _____ min.9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

12. Name **Alexander Bryant**13. Birthplace **England**14. Maiden Name **Sarah ?**15. Birthplace **England**16 (a) Informant **Baltimore City Hospital**(b) Address **Records**17 (a) **Burial** (b) Date thereof **8/19/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **St. Carmel**
Location **O'Donald St**18 (a) Funeral director **Wm. Marek**(b) Address **715 Light St****AUG 18 1943** (b)**Heating for Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-17** 19**43**, at **11:30** A.M.21. I certify that death occurred on the date above stated; that I attended
deceased from **4-3** 19**30**, to **8-17** 19**43**,
and that I last saw him alive on **8-17** 19**43**.

Immediate cause of death

? Coronary Thrombosis

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 8 months of death)

Date of operation **None**

Major findings of operations _____

of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature **Donald B. Stelt**Address **Baltimore City Hosp** Date signed **8-17-43**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07356

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07356

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Male

5. Color of face

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

68 1 2

If less than one day

hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) AUG 18 1943

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him live on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

8-18-43

Richard Weinberger

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07357

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2805 GARRISON AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) Baltimore Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5112 Edmondson Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Ella V. Pierpont

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Lafayette Pierpont

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1870

8. AGE:

Years

Months

Days

If less than one day

73

4

1

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
MOTHER

12. Name Samuel M. Keen

13. Birthplace Rock Run, Harford Co., Md.

14. Maiden Name Mary Knight

15. Birthplace Darlington, Harford Co., Md.

16 (a) Informant Mr. Richard M. Keen

(b) Address 3609 Liberty Heights Ave.

17 (a) Burial (b) Date thereof Aug 19, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium Rock Run Cemetery

Location Harford County, Md.

18 (a) Funeral director William L. Amorson

(b) Address 4510 Liberty Heights Ave.

19 (a) 18, 1943 (b) by re Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1943 at 10:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Aug 16 1943 and that I last saw him alive on Aug 16 1943

Immediate cause of death

Cerebral hemorrhage

Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward A. Morison M. D.

Address 4203 Hooper Ave. Bridgemoor, Md. Date signed Aug 17 1943

HEALTH DEPARTMENT—CITY OF BALTIMORE

07358

CERTIFICATE OF DEATH

183a G 07358

PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Outer St. 2 Ward)Length of residence in city or town where death occurred 7 yrs. 5 mos. 5 ds. How long in U. S. If of foreign birth 18 yrs. 0 mos. 0 ds.2. FULL NAME Cecilia Pettinato

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U. S. Veteran specify WAR _____

(a) Residence: No. 105 S. Outer St. _____ Ward. _____
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married6a. If married, widowed, or divorced HUSBAND of Anthony Pettinato (or) WIFE of _____6. DATE OF BIRTH (month, day, year) June 30 18767. AGE 67 Years 2 Months 19 Days 1 day, 19 hrs. 19 min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____12. BIRTHPLACE (city or town) Italy (State or country) _____13. NAME Proquale Capalupa14. BIRTHPLACE (city or town) Italy (State or country) _____15. MAIDEN NAME Cecilia Mustagi16. BIRTHPLACE (city or town) Italy (State or country) _____17. INFORMANT Anthony Pettinato (Address) 105 S. Outer St.18. BURIAL, CREMATION, OR REMOVAL Place Navy Yard Date Aug 19 194319. UNDERTAKER Wendell J. Chapel (Address) 312 S. Highland Ave

20. _____ 19 _____ Registrar. _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 15, 194322. I HEREBY CERTIFY That I attended deceased from June 1942 to Aug 15, 1943I last saw him alive on Aug 15, 1943 Death is said to have occurred on the date stated above, at 3 p.m.

The principal cause of death and related causes of importance were as follows:

Hemorrhage into cerebrum 3 days

Other contributory causes of importance: _____

Was an operation performed? No Date of _____

For what disease or injury? _____

Name of operation _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? + Date of injury _____, 19 _____

Where did injury occur? _____

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No If so, specify _____(Signed) Milton L. Solomon M. D.(Address) 129 S. Bayway

Huntington Williams, M.D.

G 07359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07359

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Sparrows Point

(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 H Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Hiram Eugene Stauffer, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14, 1943

8. AGE:

Years

Months

Days

If less than one day

3

hr.

min.

9. Birthplace Johns Hopkins Hospital

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

FATHER

12. Name Hiram Stauffer

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Doris Owens

15. Birthplace Maryland

16 (a) Informant hospital records

(b) Address Johns Hopkins Hospital

17 (a) Burial (b) Date thereof Aug-19-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

J. B. Connolly

Eastern Ave.

(Date rec'd by registrar)

H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1943 at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended
deceased from August 14, 1943. August 17, 1943
and that I last saw him alive on August 17, 1943.Immediate cause of death congenital
heart disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Gilbert J. Vorburgh

M. D.

Address

Date signed

G 07360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07360
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1823 N Bond St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1823 N. Bond St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Elizabeth Rebbel

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

Widow

6 (b) Name of husband or wife

Philip C Rebbel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 17 1876

8. AGE: Years

Months

Days

If less than one day

6763029

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

George Brown

13. Birthplace

Ireland

14. Maiden Name

Jennie Lee

15. Birthplace

Ireland

16 (a) Informant

Margaret Taylor

(b) Address

1823 N. Bond St17 (a) Burial

(b) Date thereof

8/19/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore Cem.

Location

Baltimore Md.

18 (a) Funeral director

J Melville Jenkins18 19432713 York Ave.

19 (a)

(b)

(Date rec'd by registrar)

Registrar

VS 144

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 16 1943 at 4 P M21. I certify that death occurred on the date above stated; that I attended deceased from April ~ 1943 to Aug 16 1943, and that I last saw her alive on Aug 16 1943.

Immediate cause of death

Edema of Lungs

Due to

Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. Gill HallAddress 16 31 E. North AveDate signed Aug 17 1943

M. D.

G 07361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07361
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband

6 (c) If alive, give age

7. Birth date of deceased (mo., day, year)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 19 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

M. D.

Address

Date signed

07362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07362
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1721 E Biddle St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Anna M. Hasel

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5, 1870

8. AGE: Years 73 Months 4 Days 13 If less than one day hr. min.

9. Birthplace Baltimore MD

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John Emge

13. Birthplace Baltimore MD

14. Maiden name (Maiden name)

15. Birthplace Baltimore MD

16 (a) Informant Joseph J. Hasel

(b) Address 1721 E Biddle St

17 (a) Date of death 8/2/43

(b) Date thereof (month) (day) (year)

(c) Cemetery or cremation Baltimore

Location Baltimore MD

18 (a) Funeral director William H. Dine

(b) Address 1317 N. Paul St

(c) Address 1317 N. Paul St

(d) Address 1317 N. Paul St

(e) Address 1317 N. Paul St

(f) Address 1317 N. Paul St

(g) Address 1317 N. Paul St

(h) Address 1317 N. Paul St

(i) Address 1317 N. Paul St

(j) Address 1317 N. Paul St

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(d) Street No. 1721 E Biddle St

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943 at 19 M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Feb 23 1943, Aug 18 1943.

and that I last saw him alive on Aug 18 1943.

Immediate cause of death

Due to

Carcinoma of

Stomach

Due to

metastatic disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Lanier

Address 100 N. Miller St

Date signed 8/18/43

AUG 19 1943

G 07363

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07363

77d

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3054 Arlands Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

RICHARD

SMITH

3 (b) If veteran, name war

No. 10

3 (c) Social Security Account

No. 224-14-3915

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife

Elizabeth J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/10/1886

8. AGE:

Years

57

Months

6

Days

4

If less than one day

hr. min.

9. Birthplace

Blackburn England
(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

FATHER

12. Name

Richard Smith

13. Birthplace

England

MOTHER

14. Maiden Name

Agnes Slater

15. Birthplace

England

16 (a) Informant

Elizabeth Smith

(b) Address

Long Island, N.Y.

17 (a)

Burial

(b) Date thereof

8/19/43
(Month) (day) (year)

(c) Cemetery or crematory

Druid Ridge

Location

Lakesville, Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1943 at 8 P. M21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature H. J. Wallenwider M.D.Date signed 8-15-43 Medical Examiner

G 07364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07364
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1719 E Federal St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give area)

(d) Street No. 1719 E Federal St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME Florence G. Fluschnman

3 (b) If veteran, name war

3 (c) Social Security Account

No. NNA

4 Sex Female

5 Color or race

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theodore G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1874

8. AGE:

Years

Months

Days

If less than one day

69

3

8

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Alexander French

13. Birthplace

14. Maiden Name Catherine McCabbin

15. Birthplace

16 (a) Informant Theodore G. Fluschnman

(b) Address 1719 E Federal St

(b) Date thereof 8/21/43

(Burial, cremation, or removal)

(c) Cemetery or cremation

Location

18 (a) Funeral director

(b) Address 1217 St Paul St

19 AUG 19 1943

VB 120

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943, to Aug 18 1943, and that I last saw her alive on June 1 1943.

Immediate cause of death

Acute Dilatation of Heart

Due to

Chronic Myocarditis

Due to

Arterio-Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. J. Hall

Address 1631 E North Ave

Date signed Aug 18 1943

M. D.

07365

SRUL

BALTIMORE CITY HEALTH DEPARTMENT

G 07365

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 19 1943

(b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, limited write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17 1943 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1943 to Aug 17 1943 and that I last saw him alive on 8-17-43

Immediate cause of death

Chronic Interstitial nephritis

Due to

Due to

Other Conditions

Myocardial degeneration

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1500 N Broadway Date signed 8/18/43

Duration

2 years

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07366

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1619 Locust St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *2 1/2*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1619 Locust St.*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Howard W. Kinsey

3 (b) If veteran, name war

3 (c) Social Security Account

No. *214-03-2428*

4. Sex

M

5. Color or race

*W.*6 (a) Single, married, widowed, or divorced *M.*6 (b) Name of husband or wife *Lillie E.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 14th 1878*

8. AGE: Years Months Days

*65**1**4*

If less than one day

hr.

min.

9. Birthplace *Baltimore Md.*

(Town, county, and state)

10. Usual Occupation *Die Seller Retired*11. Industry or business *Own Dr. Care*12. Name *William*13. Birthplace *Balto Md.*14. Maiden Name *Mary Reed*15. Birthplace *Balto. Md.*16 (a) Informant *Lillie E. Kinsey*(b) Address *1619 Locust Street*17 (a) *Burial* (b) Date thereof *Aug. 21-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *Brooklyn A. & Co.*18 (a) Funeral director *William Cook Inc.*(b) Address *1217 St Paul St.**Aug 19 1943* *Huntington Williams*

VB 114

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 18-43* 19 *6.4 M*21. I certify that death occurred on the date above stated, that I attended deceased from *8/17* 19 *43* to *8/18* 19 *43*, and that I last saw him alive on *8/17* 19 *43*

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Henry B. Perkins*

M. D.

Address *203 Potosi*

Date signed

G 07367

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07367

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1628 Hollins St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joan Coral Bowen

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 12. 43

8. AGE:

Years

Months

Days

If less than one day

0

1

06

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Joseph W. Bowen

13. Birthplace M Baltimore
Earma Yocobol

14. Maiden Name Joseph W. Bowen

15. Birthplace Pa.

16 (a) Informant Earma Yocobol Bowen.

(b) Address 1628 Hollins Street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8. 19. 43
(month) (day) (year)(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Ave.

18 (a) Funeral director Robert Brooks & Son

(b) Address 1338 Hollins Street.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1943, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/16 1943, to 8/17 1943.
and that I last saw h.c. alive on 8/17 1943.

Immediate cause of death

Respiratory failure

Due to Diarrhea, acidosis,
& dehydration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Josephine E. Renshaw

Address Univ. Hospital Date signed 8/17/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07368

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 532 Oxford Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Bertha Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1904

8. AGE:

Years

Months

Days

If less than one day

39

hr.

min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Spencer

13. Birthplace

Washington, D.C.

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

William Gross

(b) Address

532 Oxford St

17 (a)

Buried
(Burial, cremation, or removal)

(b) Date thereof

8-18-43
(month) (day) (year)

(c) Cemetery or crematory

Int. ParkwayLocation Cause Grounded to Rd.

18 (a) Funeral director

Asaphus Halliday

(b) Address

801 S. of Halliday

(Date rec'd by registrar)

August 19, 1943
Washington, D.C.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

532 Oxford Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-18-1943 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Due to

Acute Congestive Cardiac Failure
(also)

Other Condition

Proctally - full term pregnancy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Howard J. Maldeis

M.D.

Date signed

8/18/43

Medical Examiner.

G 07369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07369
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2124 N. Calvert
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 17(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mary A Hasson

3 (b) If veteran, name war

3 (c) Social Security Account
No. ✓

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single6 (b) Name of husband or wife ✓6 (c) If alive, give age ✓ years7. Birth date of deceased (mo., day, yr.) July 2, 1876

8. AGE: Years Months Days If less than one day

67615hr.min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

at homeFATHER
MOTHER12. Name Patience Hasson13. Birthplace Ireland14. Maiden Name Margaret Harkness15. Birthplace Baltimore, Md.16 (a) Informant Mrs Mary P. Hartigan(b) Address 3104 Hunter St17 (a) burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. Peter's Cems.Location 1309 Maryland Ave.18 (a) Funeral director John J. Conway & Son(b) Address 901 E. 3rd St.19 (a) AUG 19 1943 Registrar

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1943, at 11:45 AM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions Hypertensive
Cardio-vascular disease
(Include pregnancy within 3 months of death)22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature Hugh R. McQuillan M.D.Signed 8/18/43 Medical Examiner.

G AB-83230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 302G 07370
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 102 N. Maderia St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Julia Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married-separated

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-1889

8. AGE:

Years

Months

Days

If less than one day

54

7

1

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Michael Brown (D)

13. Birthplace Va.

14. Maiden Name Julia ? (D)

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 8/19/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery, or crematorium

Location Mt. Calvary

18 (a) Funeral director E. L. Serjman

(b) Address 1000 N. ...

AUG 19 1943 (b) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1943, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended the deceased from 8/14 1943 to 8/16 1943

and that I last saw her alive on 8/16 1943

Immediate cause of death Prob. cerebral embolus or thrombosis

under fibrillation

Due to Hypertensive (C.V. disease); 10-11 mm

past acute myocarditis

Due to

Other Conditions Latent Syphilis; old left hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: mural thrombus, left ventricle; C.P.C. of lungs; only C.P.C. cause of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury E. L. Serjman M.D.

23. Signature B C H

Address B C H

Date signed 8/19

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. G 07371

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution: University Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 0027
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County MD
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 812 Ostrand St
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME PRISCILLA GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Steve Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 23, 1881

8. AGE:

Years

Months

Days

If less than one day

61

8

23

hr.

min.

9. Birthplace

Cambridge, Maryland

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Hesley Green

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Ida Green

(b) Address

812 Ostrand St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8/20/43

(c) Cemetery or crematory

Mt Auburn

Location

18 (a) Funeral director

Elroy Wilson

(b) Address

1000 Brentley Ave

AUG 19 1943

(Date rec'd by registrar)

(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1943 at 6:10 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic

cardiovascular

disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature H. J. Wallenwider M.D.Date signed 8-17-43

G 07372

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07372

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 404 S. Dean Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charlotte M. Ruth

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 24, 19408. AGE: Years Months Days If less than one day
3 3 23 hr. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Charles Ruth13. Birthplace Balto.14. Maiden Name Josephine Wiessner15. Birthplace Balto., Md.16 (a) Informant Mrs. Josephine Ruth(b) Address 404 S. Dean St.17 (a) Burial (b) Date thereof 7 / 21 / 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory OaklawnLocation Eastern Ave18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19 (a) AUG 19 1943
(Date)Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17- 1943, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-17-43 at 3:50 P.M.(b) Where did injury occur? 404 S. Dean Street(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No(d) Means of injury Fell from 2nd floor window23. Signature Howard J. Wiessner M.D.

Medical Examiner.

Signed 8-18-43

Age is especially important. Physicians: please write the causes of death clearly and legibly.

The correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 07373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07373
99

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Dickelanel & Rayner*

(c) Hospital or institution:

West Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County *Frederick*

(c) City or town *Mt. Airy - R. F. D. #3*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *R. F. D. #3*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Luck

(Robert Clifton Luck)

3 (b) If veteran, name war

--

3 (c) Social Security Account
No. *216-10-9301*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife *Grace A. Luck*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 1, 1888*

8. AGE:

Years

Months

Days

If less than one day

55

2

16

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Clergyman - Truck Driver*

11. Industry or business *Rice's Bakery*

12. Name *Robert Luck*

13. Birthplace *Balto., Md.*

14. Maiden Name *Laura Maul*

15. Birthplace *Balto., Md.*

16 (a) Informant *Mrs. Grace A. Luck*

(b) Address *Mt. Airy, Md.*

17 (a) *Burial* (b) Date thereof *8/20/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Western Cem.*

Location *Balto., Md.*

18 (a) Funeral director *WM. J. TICKNER & SONS*

(b) Address *Baltimore, Md.*

1943
(Date rec'd by Registrar)

(b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 17 1943, 11:25 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *8/17 1943* to *8/17 1943*, and that I last saw him alive on *8/17 1943*.

Immediate cause of death

Intestinal Obstruction

Due to *Mesenteric Thrombosis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *8/12/43*

Major findings of operations

Mesenteric Thrombosis

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Jason W. Cheek*

Address *W.B.G.N.* Date signed *8/17/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07374

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **6009 Falls Road**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **68yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **6009 Falls Road**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mary Ann Murphy

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.**Married**6 (b) Name of husband or wife **Lawrence F. Murphy Sr.**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb 4 1875**

8. AGE: Years Months Days If less than one day

68**6****14**

hr.

min.

9. Birthplace **Baltimore Md**

(Town, county, and state)

10. Usual Occupation **At home**

11. Industry or business

FATHER

12. Name **Michael Lacy**13. Birthplace **Ireland**

MOTHER

14. Maiden Name **Ann Reilly**15. Birthplace **Ireland**16 (a) Informant **Lawrence F. Murphy Sr.**(b) Address **6009 Falls Road**17 (a) **Burial** (b) Date thereof **Aug 21 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **U.S. National**Location **Baltimore Md**

18 (a) Funeral director

(b) Address **4204 Ridgewood Ave**

19 (a)

AUG 19 1943

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH **7-18 1943** at **9:45 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **7-12 1941** to **7-18 1943**.
and that I last saw he ☒ alive on **7-18 1943**.

Immediate cause of death

Cerebral Hemorrhage

Duration

2 weeks

Due to

Hypertension CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Lawrence F. Murphy Sr.**Address **3711 Falls Rd** Date signed **7-18-43**

Physician writes plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 83099 07375 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07375

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 2209 Brunt St
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ray Robinson

3 (b) If veteran, name war

3 (c) Social Security Account
No. ?

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mattie Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1909

8. AGE: Years Months Days If less than one day
34 ? 0 ? 16 ? hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

12. Name James Robinson

13. Birthplace S. C.

14. Maiden Name Janie Salters

15. Birthplace S. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 21-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director J. Brooks

(b) Address 1463 N. Carey St

19 (a) Registrar

Aug 12 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1943, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1943, to 8/18 1943 and that I last saw him alive on 8/18 1943.

Immediate cause of death

TBC meningitis

Due to Pulmonary TBC

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Serjman

Address B C H Date signed 7/18

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07376
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Dolores M. Benicewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Feb 5 - 1935

8. AGE:

Years

Months

Days

If less than one day

8

6

12

hr.

min.

9. Birthplace

Baltimore - Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Chester Benicewicz

13. Birthplace

Baltimore Md.

14. Maiden Name

Anastasia De Kowale

15. Birthplace

Balto. Md.

16 (a) Informant

Records

(b) Address

17 (a)

Burial

(b) Date thereof

Aug 20 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislas

Location

Balto. Md.

18 (a) Funeral director

John G. Duda

(b) Address

2829 Hudson Street

19 (a)

AUG 19 1943

(b) **Huntington Williams, Md.**

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

3302 Fair St. AVE

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 17 1943 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug. 17 1943** to **Aug. 17 1943**

and that I last saw **her** alive on **Aug. 17 1943**

Immediate cause of death

Shock

Duration

Due to

**7. dysentery
7. poisoning**

Due to

Other Conditions

(over)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Henry Davis

Address

John Hopkins Hosp.

Date signed

8/17/43

07377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07377

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 N. Hilton Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County -----

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1214 Havenwood Road

(If rural give location)

(e) Citizen of foreign country? ----- (Yes or No)

If yes, name country -----

3 (a) FULL NAME

William M. Coulter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Mary E. Burke

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1870

8. AGE:

Years

Months

Days

If less than one day

72

11

24

--- hr.

--- min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

John H. Coulter

13. Birthplace

Maryland

14. Maiden Name

Catherine Barranger

15. Birthplace

Maryland

16 (a) Informant Thomas E. Coulter

(b) Address 1214 Havenwood Road

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/20/43

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore, Md.

18 (a) Funeral director

H. W. Mears

805 N. Calvert Street

AUG 19 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943 at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942, to Aug 18 1943.

and that I last saw him alive on Aug. 17 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Arterio Sclerosis -
funicular

Due to

Other Conditions

Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Henry H. Homan

Address 28 E. Park Ave St

Date signed 8/19/43

M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439053
G 07378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07378

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa (b) County

(c) City or town Waynesboro
(If outside city or town limits, write RURAL and give town)(d) Street No. 23 Penn St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Stephen Staley

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife

Anna W. Moor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-16-73

8. AGE:

Years

Months

Days

If less than one day

76

5

2.

hr.

min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Wm. H. Staley

13. Birthplace

Pa

14. Maiden Name

Susanne Baldwin

15. Birthplace

Pa

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

removal

(b) Date thereof

Aug. 19, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Burns Hill

Location

Waynesboro

18 (a) Funeral director

Walter Y. Grove

(b) Address

Waynesboro Pa.

19 (a)

(b)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1943 at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 3, 1943, Aug 18, 1943.
and that I last saw him alive on Aug 18, 1943.

Immediate cause of death

Cerebral vascular
accident

Due to

Due to

Other Conditions

Re bladder

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James A. Swigler

Address

J. H. Hospital

Date signed 8/10/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07379

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 623 S. Rose Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

Michael Rachubinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife ZUZANNA GORCZEWICZ

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sep 22 1875

8. AGE:

Years

Months

Days

If less than one day

67

10

26

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

John Rachubinski

13. Birthplace

Poland

14. Maiden Name

Jadwiga ?

15. Birthplace

Poland

16 (a) Informant

Mrs. Zuzanna Rachubinski

(b) Address

623 S. Rose Street

17 (a)

Burial

(b) Date thereof

8/21/43

(c) Cemetery or crematory

Holy Rosary cm

Location

Baltimore County

18 (a) Funeral director

John M. Welby

(b) Address

401 S. Chester Street

19 (a)

Date of registration

Aug 19 1943

(b)

Signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

623 S. Rose Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17

1943

at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Aug 17 1943.

Immediate cause of death

Advanced Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward J. Thompson

Address

2649 Eastern Ave

Date signed

9/1/43

Please write the causes of death clearly and legibly.

G 19 1943

VS 114

Huntington Williams

G 07380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07380
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3333 N. Charles St.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3333 N. Charles St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Helen Lillian C. Michael

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or divorced.
widowed

6 (b) Name of husband or wife George B. Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1860

8. AGE: Years 83 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Thorndyke Chase

13. Birthplace Baltimore, Md.

14. Maiden Name Clementine G. Darrell

15. Birthplace Baltimore, Md.

16 (a) Informant Bessie H. Krebs

(b) Address 5002 Frederick Road

17 (a) Burial (b) Date thereof 8/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Greenmount

Location North & Greenmount Aves., Balto

18 (a) Funeral director John A. Mitchell's Sons, Inc.

(b) Address 1906 Eutaw Place

AUG 19 1943

(Date rec'd by Registrar)

(c) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1943, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1942, to 8/18 1943, and that I last saw her alive on 8/18 1943.

Immediate cause of death

Carcinoma of Lung

Duration

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. R. Gurburgh M. D.

Address 2923 St. Paul St. Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07381

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1204 W. Cold Spring Lane
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore City
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1204 W. Cold Spring Lane
 (If rural give location)
 (e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME

John T. McNally

3 (b) If veteran, name war
no3 (c) Social Security Account
No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Widower

6 (b) Name of husband or wife Mary E. McNally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1868

8. AGE: Years	Months	Days	If less than one day
74	9	12	hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Retired Constable

11. Industry or business People's Court

12. Name John T. McNally

13. Birthplace unknown

14. Maiden Name Henrietta Warfield

15. Birthplace Howard Co. Md.

16 (a) Informant Miss Rita McNally

(b) Address 1204 W. Cold Spring Lane

17 (a) Burial (b) Date thereof 8/20/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto. City

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave.

19 (a) AUG 19 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1943, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1943 to 8/17 1943, and that I last saw him alive on 8/17 1943.

Immediate cause of death Infection of foot

Duration

Due to Arterial embolism, foot.

Due to Cardio-vascular-renal disease.

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. N. McNally

Address 1800 N. Charles St. Date signed 8/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07383
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days

(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1417 Hollins Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.

3 (a) FULL NAME GEORGE RUDOLPH ERLER

3 (b) If veteran, name war

Sp. American & World War

3 (c) Social Security Account

No. -

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife Millicent Woodring

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1874

8. AGE: Years Months Days If less than one day
69 4 1 hr. min.

9. Birthplace Saxony, Germany

(Town, county, and state)

10. Usual Occupation Printing Office Binder

11. Industry or business (Have not worked last 4 yrs)

12. Name Frederick Erler

13. Birthplace Germany

14. Maiden Name Bertha Wetzis

15. Birthplace Germany

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Entombment (b) Date thereof 8/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

(c) City or town Baltimore, Md.

AUG 20 1943

VB 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Aug. 18, 1943 at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1943 to Aug. 18, 1943, and that I last saw him alive on Aug. 18, 1943.

Immediate cause of death Bronchopneumonia

Duration

1 week

Due to Generalized reticulum cell lymphosarcoma with extensive metastases

Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Emerson G. Gledhill

Address Baltimore, Md. Date signed 8/19/43

Va-13427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07384

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2038 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Albert S. Hyman

3 (b) If veteran, name war
Unknown

3 (c) Social Security Account
No. 218-18-6006

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None
6 (c) If alive, give age * - years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1888

8. AGE: Years 55 Months 6 Days 22 If less than one day

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Machine operator

11. Industry or business Hat Factory

12. Name Samuel Hyman

13. Birthplace Baltimore Md.

14. Maiden Name Maria Amick

15. Birthplace Baltimore Md.

16 (a) Informant Mr. Samuel P. Hyman (Bro.)

(b) Address 2038 E. North Ave.

17 (a) Burial (b) Date thereof Aug. 21, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E. North Ave. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

AUG 20 1943 (Date rec'd by registrar) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1943 at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6, 1943, to Aug. 18, 1943, and that I last saw him alive on Aug. 18, 1943.

Immediate cause of death Pulmonary
Tuberculosis

Duration
Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *A. H. H. H.*

Address 1927 E. North Ave. Date signed 8/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07385
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12 1/2 E. Mt. Vernon Pl.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 12 1/2 E. Mt. Vernon Pl.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Terry Whiteley

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 218-10-6754

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife ELIZABETH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1897

8. AGE:

Years

Months

Days

If less than one day

55

11

19

hr.

min.

9. Birthplace CENTREVILLE, MD.

(Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business BETH SHIPYARD

FAIRFIELD

12. Name WHITELEY

13. Birthplace UNKNOWN

14. Maiden Name UNKNOWN

15. Birthplace UNKNOWN

16 (a) Informant ELIZABETH WHITELEY

(b) Address 12 1/2 MT. VERNON PLACE

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery UNIVERSITY MEDICAL SCHOOL AUG 19 1943

Location

18 (a) Funeral director Huntington Williams, M.D.

(b) Address

19 AUG 20 1943 (b) Huntington Williams, M.D.

F0298

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/24

43, at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McVae, M.D.

Date signed 7/26/43

Medical Examiner.

G 07386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07386

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

208 South Penn Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Mc Fadden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 7, 1943

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

n

12. Name

Wm. T. Mc Fadden

13. Birthplace

South Carolina

14. Maiden Name

n Madalene Lowry

15. Birthplace

o South Carolina

16 (a) Informant

(b) Address

w (Birth Certificate)

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Location

UNIVERSITY MEDICAL SCHOOL AUG 19 1943

Huntington Williams, Md

18 (a) Funeral director

(b) Address

19 (a)

AUG 20 1943

(Date rec'd by registrar)

Huntington Williams, Md

F0299

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 9 1943 at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Grubbs MD.

Date signed

August 10 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

✓ G 07387
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert + Farago*

(c) Hospital or institution:

Imperial Hospital 3-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Balt.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1000 Granby*

(e) Citizen of foreign country

If yes, name country *Italy*

(Yes or No)

3 (a) FULL NAME

Joseph Rei

3 (b) If veteran name was

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. *S*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1904

8. AGE:

Years

Months

Days

If less than one day

39

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

chef

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Location

*UNIVERSITY MEDICAL SCHOOL - AUG 19 1943
Huntington Williams, Md.*

18 (a) Funeral director

(b) Address

Huntington Williams, Md.

AUG 20 1943

(b)

Registrar

VS 150

0300

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 29 1943* at *4:30 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *July 27 1943* to *July 29 1943*, and that I last saw him alive on *July 27 1943*.

Immediate cause of death

Diabetes

Due to

(over)

Due to

Other Conditions

Failure of renal function

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

*Marion L. Schmitt, M.D.
Imperial Hospital*

Date signed

7/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07388
JL - 83274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07388
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **2da**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) **State Maryland** (b) County **16**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1702 Ditman Court**
(If rural give location)
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country

3 (a) FULL NAME

Rebecca Biscoe

3 (b) If veteran, name war

3 (c) Social Security Account
No. **?**

4. Sex
F

5. Color or race
C

6 (a) Single, married, widowed, or
divorced. **Married**

6 (b) Name of husband or wife **Harry Biscoe**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 24, 1900**

8. AGE: Years Months Days If less than one day
43 1 13 hr. min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation **?**

11. Industry or business

FATHER 12. Name **Nat. Harris**

13. Birthplace **Md**

MOTHER 14. Maiden Name **Sarah ?**

15. Birthplace **Md.**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **8/21/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn**
Location **West part Md.**

18 (a) Funeral director **Geo. H. Alexander**

(b) Address **927 N. Mount St.**

19 (a) **Washington Williams**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-17** 19 **43** at **4:45** M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from **8-16** 19 **43** to **8-17** 19 **43**,
and that I last saw him alive on **8-17** 19 **43**.

Immediate cause of death

Intestinal Obstruction

Due to **Hypertension**

Due to **Myometria Ateri**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Anna B. H. H.** M. D.
Address **Baltimore, Md.** Date signed **8-17-43**

Duration

2 hrs

?

9 yrs

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

AUG 20 1943

G 07389

BALTIMORE CITY HEALTH DEPARTMENT

G 07389

CERTIFICATE OF DEATH 467

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2564 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) no

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

3 (a) FULL NAME

Bessie Lee Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Richard J Pierce

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 30 - 1885

8. AGE

Years

Months

Days

If less than one day

9. Birthplace North Carolina State

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

same

FATHER

12. Name

Thompson Blanchard

MOTHER

13. Birthplace

North Carolina

14. Maiden Name

Unknown

15. Birthplace

North Carolina

16 (a) Informant

Richard J Pierce

(b) Address

2564 Edmondson Ave

17 (a)

Burial

(b) Date thereof Aug 31 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western Cem

Location

18 (a) Funeral director

Charles P Powell

(b) Address

2427 Edmondson Ave

19 (a)

AUG 30 - 1943

Huntington, W. Va.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2564 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1943 to Aug 18 1943 and that I last saw him alive on

Immediate cause of death

Carcinoma of Rectum

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

Carcinoma

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles A. Powell

Address

2145 W Balto

Date signed

8/18/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 07390
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution:

Union Memorial Hospital 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ca.

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1st Station 25, Box 1104

Chesapeake Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Rita Paulen Bailey

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

SINGLE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH - 28 - 1943

8. AGE: Years Months Days

X 4 21

If less than one day

hr.

min.

9. Birthplace Point Pleasant, W. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Black Burn Bailey, Jr.

13. Birthplace West Va.

14. Maiden Name Lucille Underwood

15. Birthplace West Va.

16 (a) Informant Black B. Bailey - (FATHER)

(b) Address 1104 Chesapeake Ave. 1st Station 25, Brooklyn, Md.

17 (a) Burial (b) Date thereof 8 - 20 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory GLEN HAYEN

Location GLEN BURNIE - Md. (A.A.C.O.)

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (F. WOODEN SQ.) 100 W. NORTH AVENUE

19 AUG 20 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1943, 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1943 to Aug. 19 1943, and that I last saw him alive on Aug. 19 1943.

Immediate cause of death

Staphylococci
Septicemia

Due to

Furunculosis

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Haddad Jr.

Address 33rd & Calvert Date signed 8/19/43

Duration

Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07391

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

University of Md. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

2 da

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

♂

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Louise Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 23-18

8. AGE:

Years

Months

Days

If less than one day

55

1

not known

hr. min.

9. Birthplace

Maryland

10. Usual Occupation

B.F.O.R. laborer

11. Industry or business

12. Name

Not known

13. Birthplace

S.C.

14. Maiden Name

Not known Celena

15. Birthplace

S.C.

16 (a) Informant

Mrs. Margaret Jackson

(b) Address

1034 W. Franklin St

17 (a)

Burial

(b) Date thereof

8-21-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Mt. W. Mans - Md.

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 S. Schrevels St.

19 (a)

Date of death

August 17, 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1034 Franklin St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

* MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17 1943 at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1943 to Aug 17 1943, and that I last saw him alive on Aug 16 1943

Immediate cause of death

Respiratory failure

Duration

Due to

Cerebro vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

David Hargan

Address

4 of Md. Hospital

Date signed

8/17/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AUG 20 1943

G 07392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07392

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4311 Penhurst Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3415 Holmes Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

GLADYS WICKES

3 (b) If veteran, name war

--

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife Joseph A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1868

8. AGE: Years Months Days If less than one day
75 0 28 hr. min.9. Birthplace Kent Co., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Joseph T. Robinson

13. Birthplace Va.

14. Maiden Name Anna Delano

15. Birthplace Va.

16 (a) Informant Joseph A. Wickes

(b) Address School of Law, Austin, Texas

17 (a) Burial (b) Date thereof 8/21/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Chester Cemetery
Location Chestertown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)

AUG 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1943, 4:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1943, to Aug 18, 1943, and that I last saw her alive on Aug 18, 1943.

Immediate cause of death

congestive heart failure

Duration

3 days

Due to Chronic myocarditis

with hypertension, and

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

Means of injury

Signature Maurice E. Shamer

Address 3800 N. Indiana Date signed 8/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07393

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07393

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3917 Pinkney Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 3917 Pinkney Rd. *Beth.*
(If outside city or town limits, write RURAL and give town)

(d) No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARGARET E. LANGGOOD

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. 218-12-2073

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single.

6 (b) Name of husband or wife

--

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1922

8. AGE: Years Months Days If less than one day
20 9 11 hr. min.

9. Birthplace Pikesville, Md.

(Town, county, and state)

10. Usual Occupation Telephone Operator

11. Industry or business C. & P. Telephone Co.

12. Name Charles J. Langgood

13. Birthplace Baltimore, Md.

14. Maiden Name Emma Holland

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles J. Langgood

(b) Address 3917 Pinkney Rd.

17 (a) Burial (b) Date thereof 8/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Charles Ch. Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address North & Pa., Balto., Md.

19 AUG 20 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1941 to Aug 17 1943 and that I last saw her alive on Aug 14 1943.

Immediate cause of death

Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

1123-57

Date signed

D.

HUGH VIELCH

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07394

CERTIFICATE OF DEATH

83a

G 07394

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3139 Keswick Rd. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. 3139 Keswick Rd. St. 13-5 Ward

(Usual place of abode)

If U. S. Veteran specify WAR

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Male 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married6a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Stella Andrews6. DATE OF BIRTH (month, day, year) May 24, 18707. AGE 73 Years Months 2 Days 24 If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Shipping Clerk
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Shipping Clerk
10. Date deceased last worked at this occupation (month and year) Apr. 1931 11. Total time (years) spent in this occupation 3012. BIRTHPLACE (city or town) Baltimore, Md. (State or country)13. NAME Robert Andrews14. BIRTHPLACE (city or town) Baltimore, Md. (State or country)15. MAIDEN NAME Sarah A. Whitehouse16. BIRTHPLACE (city or town) England (State or country)17. INFORMANT Mrs. Stella Andrews (Address) 3139 Keswick Rd.18. BURIAL, CREMATION, OR REMOVAL Mountland Park Date Aug 21, 194319. UNDERTAKER Chenoweth & Sonoran (Address) 3612-17 Chestnut Ave.

AUG 20 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 18, 194322. I HEREBY CERTIFY, That I attended deceased from Jan. 1943 to Aug. 18, 1943I last saw him alive on Aug. 18, 1943 Death is said to have occurred on the date stated above, at 10:30 A.M.

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis
Cerebral hemorrhage

Other contributory causes of importance:

Possibly: NephritisWas an operation performed? no Date of —For what disease or injury? —Name of operation —What test confirmed diagnosis Clinical Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury —Where did injury occur? — (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place —Manner of injury —Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify —(Signed) Tom M. Langbaker M. D.(Address) 2740 St. Paul St.

OCCUPATION is very important. See instructions on back of certificate.

G 07395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07395

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town 4318 Ridge Avenue, Halethorpe, Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4318 Ridge Ave., Halethorpe, Md.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

FRANCIS SPALDING MYERS

3 (b) If veteran, name war

World's War I

3 (c) Social Security Account

No. 218-10-4861

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Agnes Woutiseth

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 7/29/94

8. AGE: Years Months Days If less than one day

49

0

20

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Laborer, Ships Supply Warehouse

11. Industry or business

12. Name John W. Myers

13. Birthplace Baltimore, Md.

14. Maiden Name Mary ? Cronan

15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) (b) Date thereof Aug 21-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto Nat. Cem

Location Balto - Md.

18 (a) Funeral director John R. Berry

(b) Address 1242 Red Fox Rd, 15th

19 (a) 20 AUG 20 1943

VA 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 18, 1943, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4, 1943, to Aug. 18, 1943,

and that I last saw him alive on Aug. 18, 1943

Immediate cause of death Oligodendroblastoma of both frontal lobes

Duration 4 mos.

approx.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/17/43 - Craniotomy, partial resection of Rt. frontal lobe tumor

Findings: As above

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/18/43

VA-13515

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07396

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-19, 1943, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-1943 to 8-19-1943 and that I last saw him alive on 8-19, 1943

Immediate cause of death

Duration

Due to

Basal Ganglia Hemiplegia

9 days

Due to

Hypertension

Other Conditions

Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Jenny Murnighan

M. D.

Address

Date signed 8-19-43

AUG 20 1943

G 07397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07397
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2133 W. FAYETTE STREET

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 2133 W. FAYETTE ST.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MINNIE ELLEN TAPMAN

3 (b) If veteran, name war

✓

3 (c) Social Security Account
No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

WIDOWED

6 (b) Name of husband or wife

GEORGE CHARLES

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 5-10-1871

8. AGE:

72

3

87

If less than one day

hr.

min.

9. Birthplace

PHILA. PA.

(Town, county, and state)

10. Usual Occupation

HOUSE WIFE

11. Industry or business

12. Name

UNKNOWN

13. Birthplace

14. Maiden Name

MARY ELLEN THOMPSON

15. Birthplace

PHILA. PA.

16 (a) Informant

EDWARD W. TAPMAN

(b) Address

4255 LYANHOE AVE

17 (a)

BURIAL

(b) Date thereof

7-21-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

LOURDON PARK

Location

BALTIMORE, MD.

18 (a) Funeral director

Hendrickson & Co.

(b) Address

1200 N. Lombard St.

19 (a)

AUG 20 1943

(b)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17 1943 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943 to 8-17 1943, and that I last saw him alive on 8-16 1943.

Immediate cause of death

Arterio Sclerosis

Duration

Due to

Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

2150 E. Baltimore

Date signed

8/19/43

Correct age is extremely important. Physicians, please write true age.

G 07398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

JL - 83316

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 228 Colvin St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Carrie Murdock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19 9 1892

8. AGE: Years Months Days If less than one day
51 9 5 0 hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Peter Jarvis

13. Birthplace Md

14. Maiden Name Adeline Madden

15. Birthplace Md

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/23/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Joseph B. Locke, Jr.

(b) Address 136 x N. Central

19 (a) AUG 20 1943 (b) Registrar

VS 100

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1943 at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1943 to 8-19 1943, and that I last saw him alive on 8-19 1943.

Immediate cause of death

Intestinal Obstruction

Duration

2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald Ballert

Address Balto City Hosp Date signed 8-19-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death exactly and legibly.

073996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07399

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs. (mos.) or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1943, to 8/17 1943, and that I last saw him alive on 8/17 1943.

Immediate cause of death

Respiratory failure

Due to

Dehydration

Due to

Diarrhea

Other Conditions

Rickets

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Renshaw

Address

Union Hospital

Date signed

8/18

AUG 20 1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07400
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mrs Esther C. Galloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Harry Galloway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/7/1893

8. AGE:

Years

Months

Days

If less than one day

49

10

14

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

MOTHER

12. Name

Eugene F. Galloway

13. Birthplace

France

14. Maiden Name

Ella Jones

15. Birthplace

Ind.

16 (a) Informant

Hosp Records

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 22, 1943

(month) (day) (year)

(c) Cemetery or crematory

Baker Cemetery

Location

Aberdeen Md

18 (a) Funeral director

Wm J. Tucker & Son

(b) Address

N + R Ave

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

AUG 20 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Harford

(c) City or town

Aberdeen Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

238 Park St

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20 1943 at 145 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Aug 20 1943, and that I last saw him alive on Aug 20 1943.

Immediate cause of death

Bleeding

abortion
Due to carcinoma of the Ampulla of Vater

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams

Address

Mercy Hosp.

Date signed

8-20-43

G 07401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G 07401

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1201 Heldon Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male

5 Color of race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna Agnes O'Hara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24-1872

8. AGE: Years 71 Months 1 Days 24 If less than one day hr. min.

9. Birthplace Ireland

10. Usual Occupation Overseer Textile

11. Industry or business Retired 12 years

12. Name P'Hara

13. Birthplace Ireland

14. Maiden Name Unknown

15. Birthplace Ireland

16 (a) Informant Mrs Anna Agnes O'Hara

16 (b) Address 1201 Heldon Ave

17 (a) Burial (b) Date thereof Aug. 21-1943

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director Surgeon's Funeral Home

(b) Address 3631 Falls Road

19 (a) Trusting for William M. H.

AUG 20 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1201 Heldon Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18-1943, at 10⁵⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1943 to Aug 18 1943, and that I last saw him alive on Aug 16 1943.

Immediate cause of death

Cerebral haemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward J. Herman

Address 4037 Fabe Rd. Date signed 8/19/43

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07402
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

402 S. Smallwood St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Margaret F. Farnsworth

6 (c) If alive, give age

2 years

7. Birth date of deceased (mo., day, yr.)

May 20, 1891

8. AGE:

Years

Months

Days

If less than one day

52

2

2

hr.

min.

9. Birthplace

Emmorton, Harford Co.

(Town, county, and state)

10. Usual Occupation

Retail Handler

11. Industry or business

Whitingham Co.

FATHER

12. Name

Frank B. McGinness

13. Birthplace

Emmorton, Harford Co.

MOTHER

14. Maiden Name

Mary A. Grant

15. Birthplace

Harford Co., Md.

16 (a) Informant

Mrs M. McGinness

(b) Address

402 S. Smallwood St

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

8/21/43

(month) (day) (year)

(c) Cemetery or crematory

St Paul's Cemetery

Location

High Street

18 (a) Funeral director

Geo. F. Kennedy

(b) Address

1600 Hollins St.

19 (a)

AUG 20 1943

Huntington Hill, Md.

(b) Date of death

August 17, 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

402 S. Smallwood St

(If rural give location)

(e) Citizen of foreign country?

No

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17 1943 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1943 to Aug 17 1943 and that I last saw him alive on Aug 17 1943

Immediate cause of death

Coronary Thrombosis 2 years

Due to (new)

Other Conditions Rheumatism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles A. Cullen

Address

2145 W. Belts Rd

M. D.

Date signed

G 07403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 727 S. Potomac St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 727 S Potomac St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph Kazmierczak

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1276

8. AGE:

Years

Months

Days

If less than one day

67

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation

Cabinet maker

11. Industry or business

FATHER
MOTHER

12. Name Joseph

13. Birthplace Poland

14. Maiden Name Unk

15. Birthplace Poland

16 (a) Informant Katherine KAZMIERCZAK

(b) Address 727 S Potomac St

17 (a) Burial, cremation, or disposal

(b) Date thereof Aug 21/43

(c) Cemetery or cremation location Holy Redeemer

18 (a) Funeral director Fred W. Ozyanski

(b) Address 1930 Eastern Ave.

19 (a) Registrar

AUG 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1943 at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to Aug 18 1943, and that I last saw him alive on Aug 17 1943.

Immediate cause of death

Arteriosclerosis of Aorta
Chronic myocardial

Due to Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide None

(b) Date of occurrence None at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ed Schumacher

Address 842 E. Ave Date signed E-20-43

Duration

8-14-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07404

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3101 Clifton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3101 Clifton Ave.

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Eleanor Brown Harris

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1876

8. AGE: Years Months Days If less than one day

67

4

2

hr.

min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Gerald Brown

13. Birthplace Ireland

14. Maiden Name O'Brien

15. Birthplace Ireland

16 (a) Informant Gerald Harris

(b) Address 3101 Clifton Ave

17 (a) Burial (b) Date thereof Aug 21 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Lorraine Cem.

18 (a) Funeral director

(b) Address 7401 Belair Rd.

19 (a) AUG 20 1943 (b) Burial

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19th 1943, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943, to Aug 19 1943, and that I last saw her alive on Aug 1 1943.

Immediate cause of death Coronary occlusion

Duration

10 min.

Due to advanced arteriosclerosis. P

Due to Hypertension P

Other Conditions Coronary disease P

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Walter S. Tubert M. D.

Address 2220 Harrison Date signed Aug 19/43

G 07405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07405
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Murray Hoof

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

3 (a) FULL NAME

James Vagnoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

20

hr.

min.

9. Birthplace

Reisterstown, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Ernest Vagnoni

13. Birthplace

Italy

14. Maiden Name

Jenny

15. Birthplace

Italy

16 (a) Informant

Ernest Vagnoni

(b) Address

Reisterstown, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 21, 1943

(c) Cemetery or crematory

All Saints

Location

Reisterstown, Md.

18 (a) Funeral director

Mrs. Barryman

(b) Address

Reisterstown, Md.

19 (a)

(b)

VB 154

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

Baltimore County

(c) City or town

Reisterstown, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Barryman's Lane

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20

1943, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1943, to Aug 20, 1943, and that I last saw him alive on Aug 20, 1943.

Immediate cause of death

Sudden

Due to

Due to

Other Conditions

Diabetes

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Carlton Wick

Murray Hoof

Date signed 8-20-43

Duration

Instantaneous

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07406

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3904 4th St Bklyn

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rose V. Wischke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

W.

6 (b) Name of husband or wife

John G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 7, 1890

8. AGE: Years Months Days

53

3

"

If less than one day

hr.

min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

James Sparac

13. Birthplace

Pa.

14. Maiden Name

Catharine

15. Birthplace

Pa.

16 (a) Informant

Family

(b) Address

3904 4th St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8-21-43

(c) Cemetery or crematory

Location

Garrison Hill Rd.

18 (a) Funeral director

Wilton Schaefer

(b) Address

3904 Harrison St.

19 (a)

AUG 20 1943

VS 150

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3904 4th St.

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18

1943 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Aug 18 1943, and that I last saw him alive on Aug 18 1943.

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertensive cardiac vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Philip W. Keister, M.D.

Address

302 Patapsco Ave

Date signed

Aug 20

PHYSICIAN

Underline the cause to which death should be charged statistically.

486123
G 07407BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 114G 07407
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1024 N. Durham
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black6 (a) Single, married, widowed, or
divorced.Married

6 (b) Name of husband or wife

Pearl Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 41 Months 1 Days 1902
If less than one day hr. min.

9. Birthplace

Ja.

(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

12. Name

Ed. Lewis

13. Birthplace

Ja.

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 21/43
(month) (day) (year)

(c) Cemetery or crematory

Int. Calvary Cem.

Location

A. G. County

18 (a) Funeral director

Robert M. Elliott & Sons

(b) Address

1129 N. Caroline St.

19 (a)

(b)

Registrar

AUG 20 1943
Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1943 5:30 PM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from June 11 1943 to Aug 18 1943,
and that I last saw him alive on Aug 18 1943.

Immediate cause of death

Metastatic brain abscess
with meningitisDue to hemolytic streptococcusDue to brain abscess &
empyema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/12/43Major findings of operations: Empyema& brain abscessof autopsy: not done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John W. SaundersAddress Johns Hopkins Hospital Date signed 8/18/43

Duration

3 mos.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07408
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2201 Calvert St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph

W. Bristor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) 12/24/1861

8. AGE: Years Months Days If less than one day

81

7

25

--- hr. --- min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Vice-Pres. U.S.F.G.

12. Name William Beverly Bristor

13. Birthplace Baltimore, Maryland

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mr. William Beverly Bristor

(b) Address 600 Hastings Rd., Towson

17 (a) Burial (b) Date thereof 8/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery Loudon Park

Location Baltimore, Md.

18 (a) Funeral director H.W. Mease & Son

(b) Address 805 N. Calvert St.

19 (a) AUG 20 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1943 A M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH 4th degree

burns of entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

OR If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 8/18/43 4:35A M

(b) Where did injury occur? 2201 Calvert St.

(c) Did injury occur at home, on farm, industrial place, in public
place? Home While at work? No

(d) Means of injury fire at home

23. Signature Robert L. Graham M.D.

Date signed Aug. 19 1943

229448-07409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07409

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1053 Annapolis St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Francisco Assaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Jennie M. Assaro

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.)

59 10/5/83

8. AGE:

Years

Months

Days

If less than one day

59

10

5

14

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Underemployed

11. Industry or business

FATHER
MOTHER

12. Name Salvatore Assaro

13. Birthplace

Italy

14. Maiden Name Christine Falzone

15. Birthplace

Italy

16 (a) Informant

Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

8/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or

Holy Redeemer

Location

Baltimore, Md.

18 (a) Funeral director

Baltimore, Md.

(b) Address

9246 C. C. Gay St

19 (a)

(b)

Registrar

AUG 20 1943
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 19 1943 10:45 P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 17 - 1943 to Aug - 19 - 1943, and that I last saw him alive on Aug - 19 - 1943.

Immediate cause of death

Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Coronary Thrombosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Robert Day

23. Signature

Johns Hopkins Hosp

Date signed 8/24/43

G 07410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07410
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) Is veteran, name war

3 (c) Social Security Account No.

Sex

5 Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date that

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State, Maryland

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1942, to Aug 19 1942, and that I last saw him alive on Aug 19 1942

Immediate cause of death

Diarrhea

Dehydration

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Josephine E. Renshaw

M. D.

Address

Univ. Hospital

Date signed 8/20

07411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G 07411

CERTIFICATE OF DEATH 1310

Reg. Dist. No.

1. PLACE OF DEATH: Balto, 743 Grantley St
 City or town Balto, Md.
 (If outside city or town limits, write RURAL and give nearest town.)
 How long in above place of death? 6 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town.)
 Street No. 743 Grantley St
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Samuel E Creager

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

7. (b) Name of husband or wife Anna L. Creager8. Birth date of deceased (mo., day, yr.) Feb 3, 1868 9. (c) If alive, give age 64 years

10. AGE: Years 75 Months 6 Days 18 If less than one day
 hrs. 18 min.

11. Birthplace Hagerstown, Md. (Town, county, and state)12. Usual occupation Machinist13. Industry or business Machinist14. Name Harry Creager15. Birthplace Maryland16. Maiden name Don't know

17. Birthplace

18. Informant William R. CreagerAddress 743 Grantley St Balto Md19. Burial 8/23/43 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md20. Funeral Director Andrew K. CoffmanAddress Hagerstown MdAUG 21 1943 Hagerstown Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21st. 1943. at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18, 1943 to Aug 21, 1943and that I last saw him alive on Aug 20, 1943Immediate cause of death arteriosclerotic cardiovascularvascular disease

DUE TO

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George A. Kupper M. D. or otherAddress 3030 E. Calver Ave. Date signed 8/24/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07412
JL - 85133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07412

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **10 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1530 Clifton Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Sydenham C. Coulter

3 (b) If veteran, name war

3 (c) Social Security Account
No. **?**

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife **Mary Emma**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 4, 1867**

8. AGE: Years **76** Months **6** Days **14** If less than one day
hr. min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Noah Coulter**

13. Birthplace **Del.**

14. Maiden Name **Laura Stall**

15. Birthplace **Md.**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **Aug 21 - 43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **St Ann's**
Location **Annapolis Md.**

18 (a) Funeral director **Harry H. Wilkie**
Edmondson Ave.

(Date rec'd by registrar)

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-18 1943 12:45 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **8-9 1943** to **8-18 1943**, and that I last saw him alive on **8-18 1943**.

Immediate cause of death

Pneumonia
Due to **Gen. Arteriosclerosis**
Due to **Coronary Sclerosis**
Myocardial Infarct
Other Conditions **Prostatic Hypertrophy**

Duration

3 days

4

?

1 day

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **above**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Ismael B. Bell** M. D.

Address **Baltimore, Md.** Date signed **8-19-43**

G 07413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07413

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 47026 Harford Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 mos 30 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Stella Thomson Niccott

3 (b) If veteran, name war

M

3 (c) Social Security Account

No.

NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1898

8. AGE: Years Months Days If less than one day

65 6 19 min.

9. Birthplace

Haythorpe, N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

AUG 21 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 19 1943 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1942 to Aug 18 1943, and that I last saw him or alive on Aug 18 1943.

Immediate cause of death

Carcinoma of left kidney

Duration

3 yrs.

Due to

Metastases to pelvis

Due to

Other Conditions

Chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. V. Harbold M.D.

Address 4706 Harford Road

Date signed 8/20/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07414

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2940 Greenmount Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Charles W. Walters.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Gussie Walters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 20th 1896

8. AGE:

Years

Months

Days

If less than one day

47

0

29

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Huckster

11. Industry or business

Self

FATHER

12. Name

Henry Walters

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Lena (Unknown)

15. Birthplace

Germany

16 (a) Informant

Gussie Walter

(b) Address

10 E. Montgomery St.

17 (a)

Burial

(b) Date thereof

8/23/43

(Burial, cremation, or reinterment)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Co. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

Huntington Williams, Md.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/19

1943 at 8:55 PM

21. I certify that I took charge of the remains described above, held an

Inspection hereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McWalters

Date signed 8/20/43. Medical Examiner.

AUG 21 1943

G 07415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07415

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

AUG 21 1943

(b) (Date rec'd by registrar)

VB 144

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20 1943 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943, to Aug 20 1943 and that I last saw her alive on Aug 20 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

Due to

arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Laurin E. Goodwin

Address 1733 Balton St

Date signed 8/24/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07416

BALTIMORE CITY HEALTH DEPARTMENT

G 07416

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2752 Pennwiche Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date of registration)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20 1943 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1943 to Aug 20 1943.

and that I last saw him alive on Aug 19 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G 07417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07417

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address CALVERT & SARATOGA STS.

(c) Hospital or institution:

MERCY HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 WKS

(e) Length of stay in Baltimore (yrs., mos., or days) 12 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2301 MAISEL ST

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN PERRY HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-10-2964

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 9, 1898

8. AGE: Years Months Days If less than one day

44

8

11

hr.

min.

9. Birthplace BELLAIRE, OHIO

(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business Tress Woodwork Co

12. Name HARRY HARRIS

13. Birthplace BELLAIRE, OHIO

14. Maiden Name MARY ELIZABETH SILVER

15. Birthplace BELLAIRE, OHIO

16 (a) Informant Sophia Harris

(b) Address 2301 Maisel St.

17 (a) Burial (b) Date thereof Aug 23, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

AUG 21 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20, 1943, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 13, 1943, to AUG 20, 1943, and that I last saw him alive on AUG. 19, 1943.

Immediate cause of death TOXEMIA

Duration

Due to STREPTOCOCCUS VIRIDANS
SEPTILEMIA

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy 1) Multiple

lung + liver abscesses; 2) Sepsis

of autopsy: abscess, iliac from abscess.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Henry F. Zangora

Address Mercy Hospital Date signed 8/20/43

G 07418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07418

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 16 1943 to Aug 19 1943.
and that I last saw h. alive on Aug 19 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally:

Correct age is especially important. Incomplete answers will cause the causes of death clearly and legibly.

AUG 21 1943

VS 154

074119

LAWTON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 074119

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 210 E. Fort Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life**2. USUAL RESIDENCE OF DECEASED:**

- (a) State Ind. (b) County
(c) City or town Balew
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAMERobert F. Lawton**3 (b) If veteran, name war****3 (c) Social Security Account No.****4. Sex**M.**5. Color or race**W**6 (a) Single, married, widowed, or divorced.**W.**6 (b) Name of husband or wife**Julia G. Schockel**6 (c) If alive, give age years****7. Birth date of deceased (mo., day, yr.)**Nov. 12, 1863**8. AGE:**

Years

Months

Days

If less than one day

1996

hr.

min.

9. BirthplaceBalto.

(Town, county, and state)

10. Usual OccupationStove Keeper**11. Industry or business****12. Name**Charles Lawton**13. Birthplace**Ind.**14. Maiden Name**Margaret Walton**15. Birthplace**Ind.**16 (a) Informant**Family**(b) Address**210 E. Fort Ave.**17 (a)**

(Burial, cremation, or removal)

(b) Date thereof8-21-43**(c) Cemetery or crematory**W.D. Oliver**Location**Triduck Ave.**18 (a) Funeral director**James H. McQuay**(b) Address**210 E. Fort Ave.**19 (a)**

(Date)

AUG 21 1943Huntington

Registrar

MEDICAL CERTIFICATION**20. DATE OF DEATH** Aug. 18, 1943 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4/1943 **to** 8/18/1943
and that I last saw him alive on 8/17/1943

Immediate cause of deathCarcinoma of bowel.**Duration**3 days

Due to

Due to

Other Conditions Intestinal obstruction.

(Include pregnancy within 3 months of death)

Date of operation**Major findings of operation:****of autopsy:****22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature Harry ReiselAddress 1226 Hanover St. Date signed 8/20/1943

07420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07420

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 7011 RAILWAY AVE.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 220-22-2178

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife ANNA E. NICKEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 16 1878

8. AGE: Years Months Days If less than one day

65

12

3

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation RETIRED MERCHANT

11. Industry or business FOR SELF

12. Name JOHN NICKEL

13. Birthplace GERMANY

14. Maiden Name MARY FAHN

15. Birthplace GERMANY

16 (a) Informant ANNA E. NICKEL (WIFE)

(b) Address 7011 RAILWAY AVE.

17 (a) BURIAL (b) Date thereof AUG. 23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zoller, Inc.

(b) Address 403 S. WOLFE ST

19 (a) (b) AUG 21 1943

(Date) (Signature) Huntingdon Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1943 at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1943 to Aug. 19 1943, and that I last saw him alive on Aug. 19 1943.

Immediate cause of death Diffuse lobular bronchopneumonia & C. Pericardial Congestion Due to aplastic anemia

Due to

Other Conditions Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Date of operation August 19 1943

Major findings of operations:

Aplastic Anemia, Congestion, Cardiac hypertrophy

of autopsy

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. B. Hagan

Address Univ. Hosp Date signed 8/19/43

Duration

PHYSICIAN

Underline the cause to which death should be attributed.

Registered No.

VB 154

G 07422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07422

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 3037 Woodland ave.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3037 Woodland
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Sarah Emily Sipes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color of race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Albert C. Sipes6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

Feb-11-1870

8. AGE: Years

73

Months

6

Days

8

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

FATHER

12. Name

George W. Oozon

13. Birthplace

Belle Co. Md.

MOTHER

14. Maiden Name

Emily Jane Ayler

15. Birthplace

Baltimore

16 (a) Informant

Mr. L. P. Seiber

(b) Address

3037 Woodland ave17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8/21/43

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Randalltown End.

18 (a) Funeral director

Frank H. Maxwell

(b) Address

Bethesda Md.

AUG 21 1943

Huntington

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/19 1943 at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Aug 19 1943, and that I last saw him alive on Aug 19 1943.

Immediate cause of death

Splenic Tumor

Due to

(no)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Frank H. Maxwell

Address

3921 Edmondson Ave

Date signed

8/21/43

Duration

10 4/12

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07423

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 773 W. Cross St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Aug-9-1906

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 21 1943

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 19 1943 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Harry Cohen

Address University Hospital

Date signed

M. D.

8/19/43

G 07424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07424

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital 22

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 704 South Shays St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1943

8. AGE: Years Months Days If less than one day

5 24 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Linwood Jarvis

13. Birthplace Va.

14. Maiden Name Nadine Thomas

15. Birthplace Maryland

16 (a) Informant Nadine Thomas

(b) Address 704 South Shays St.

17 (a) Burial (b) Date thereof Aug 23 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Calvary
Location a a Co 2nd place?

18 (a) Funeral director James A. Hayes

(b) Address 1420 W. Hill St.

19 (a) AUG 21 1943 (b) Livingston Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1943, at 12 P.M.

21. I certify that I took charge of the remains described above, held an

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury.

23. Signature Robert Lee Gratum M.D.

Date signed Aug 21 1943

07425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07425

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison @ Linden Ave*

(c) Hospital or institution:

Mayland General Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto.*(c) City or town *Glen Arm (rural)*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) FULL NAME

Mrs Clarence Elmer Blakley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Anna E. Blakley*6 (c) If alive, give age *50* years7. Birth date of deceased (mo., day, yr.) *Dec. 22, 1892*

8. AGE: Years Months Days If less than one day

50 7 29 28 hr. min.9. Birthplace *Baltimore Co., Maryland*
(Town, county, and state)10. Usual Occupation *Farmer*11. Industry or business *Self*12. Name *Amos Blakley*13. Birthplace *Maryland*14. Maiden Name *Mary Francis*15. Birthplace *Maryland*16 (a) Informant *Mrs. Anna E. Blakley*(b) Address *Glen Arm, Maryland*17 (a) *Burial* (b) Date thereof *Aug 23 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Mt. Maria Cem.*Location *Towson, Maryland*18 (a) Funeral director *John Burns Son*(b) Address *Towson, Maryland*19 (a) *AUG 21 1943* (b) Registrar *William H. Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-20-43* 19 at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *8-16-43* 19 to *8-20-43* 19 and that I last saw him alive on *8-20-43* 19

Immediate cause of death

*Meningitis
secondary to pneumonia*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Thomas C. Walster*Address *Mayland Gen. Hosp.* Date signed *8/20/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Certificate of death is a legal document. It is important that you fill it out carefully and legibly.

07426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07426
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 415 Gwynn Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 415 Gwynn Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Francesca Liberto

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife Salvatore

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1879

8. AGE:

Years

Months

Days

If less than one day

63

7

26

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name Salvatore Baranco

13. Birthplace

Italy

14. Maiden Name

Rose Strio

15. Birthplace

Italy

16 (a) Informant Angelina Liberto

(b) Address 415 Gwynn Ave

17 (a) Burial (b) Date thereof 8/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Old Frederick Rd.

18 (a) Funeral director Joseph Farago Inc.

(b) Address 2013 Greenmount Ave

AUG 21 1943

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1943, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 1941 to 1943
and that I last saw h.e.r. alive on August 18, 1943Immediate cause of death Arterio-sclerotic
cardio-vascular disease with
decompensation

Duration

2 yrs.

Due to

Due to

Other Conditions Diabetes mellitus

10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 511 Medical Arts Bldg. Date signed 8/21/43

07427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07427

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Airi Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joanna Beran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24/43.

8. AGE: Years Months Days If less than one day

2 27 26 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Joseph Beran

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Anna Sassone

15. Birthplace

New Jersey

16 (a) Informant

Joseph Beran

(b) Address

2330 E Chase St.

17

(Burial, cremation, or removal)

(b) Date thereof

Aug. 23/43

(c) Cemetery or crematory

Holy Rosary

Location

Baltimore

18 (a) Funeral director

Fred W. Ozegowski

(b) Address

1830 Eastern Ave.

AUG 21 1943

Huntington Williams

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2330 E Chase St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/20

19

at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1943 to 8/20 1943.

and that I last saw her alive on 8/20 1943.

Immediate cause of death

B. I. knowledge

Duration

Due to

cholesterol ulcer

Due to

Other Conditions

Apparition pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

cholesterol ulcer, App. Ph.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Gerard M. Neiselas

Address

Airi Hosp.

Date signed

8/20

L. E. Neiselas

correct age is especially important. Physicians: please write the cause of death clearly into Registry.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07428
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1800 Eastern Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 313 S. Chestel St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Agnes Wiedzwicki (Wiedzwick)

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Leo M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

48 - - hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Michael Zyblewski

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Leo Wiedzwicki

(b) Address 313 S. Chestel St.

17 (a) Burial (b) Date thereof Aug. 23/43

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Ozajewski

(b) Address 1930 Eastern Ave.

19 AUG 21 1943

20. DATE OF DEATH August 18 1943 at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 3 1943 to August 18 1943, and that I last saw her alive on August 17 1943.

Immediate cause of death

Carcinoma of the stomach

& metastases to liver

Due to Aortic Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 15, 1943

Major findings of operation: see above

under Cause of Death

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. Srofton Harsperger

Address 214 Medical College

Date signed 8/18/43

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1943 at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 3 1943 to August 18 1943, and that I last saw her alive on August 17 1943.

Immediate cause of death

Carcinoma of the stomach
& metastases to liver

Due to Aortic Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 15, 1943

Major findings of operation: see above

under Cause of Death

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. Srofton Harsperger

Address 214 Medical College

Date signed 8/18/43

Duration

1 year

3 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

07429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07429
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2828 Overland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

3 (a) FULL NAME

Mary Hannah Watt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Samuel Watt

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Nov 26 - 1878

8. AGE: Years 64 Months 8 Days 2234 hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

12. Name William Payne

13. Birthplace England

14. Maiden Name Hannah Harbottle

15. Birthplace England

16 (a) Informant Samuel Watt

16 (b) Address 2828 Overland Ave

17 (a) Burial (b) Date thereof Aug 23/43 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location City

18 (a) Funeral director Willist Funeral Home

19 (a) AUG 22 1943 (b) (Date rec'd by registrar) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No 2828 Overland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1943, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937 to Aug 20 1943 and that I last saw him alive on Aug 18 1943.

Immediate cause of death

Hypertensive cardiac

rheumatic aortic disease

Due to

Due to

Other Conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Peter J. Schenck

Address 2939 W. Liberty St Date signed 8/20/43

Duration

?

?

?

?

5 yrs

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07430

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 618 McCabe Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 618 McCabe Ave.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

MARY POEHLITZ

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Paul F. Poehlitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1864

8. AGE:

Years

Months

Days

If less than one day

79

0

4

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

12. Name Frederick Reese13. Birthplace Germany14. Maiden Name Mary Bunner15. Birthplace Germany16 (a) Informant Mrs. Pauline Wagner(b) Address 618 McCabe Ave.,17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug. 23, 1943

(month) (day) (year)

(c) Cemetery or crematory Mt. CarmelLocation Baltimore, Md.18 (a) Funeral director Ullrich Funeral Home(b) Address 2008 Orleans St.

19 (a)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1943 19 11:30 A21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16, 1943 to Aug. 19, 1943 and that I last saw him alive on Aug. 19, 1943

Immediate cause of death

Coronary ThrombosisDuration 3 days

Due to

Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature W. H. Williams, M.D.Address 212 N. Charles Date signed Aug. 23, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the dates of death clearly and legibly.

AUG 23 1943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07431

G 07431

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 412 W. Pearl St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Sophie

Stewart

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE:

Years

Months

Days

If less than one day

75

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Old Age Pensioner

11. Industry or business

FATHER

12. Name

13. Birthplace

Unknown

14. Maiden Name

15. Birthplace

16 (a) Informant

Mrs. Annie Massey

(b) Address

412 Pearl St.

17 (a)

Burial

(b) Date thereof

8/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cemetery

Location

Anne Arundel Co. Md.

18 (a) Funeral director

Adolphus Halstead

(b) Address

918 Druid Hill Ave.

19 (a)

8/22/43

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1943, at 10 AM

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis

Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert E. Guter M.D.

Date signed

August 19 1943

G 07432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07432
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33 + Calvert

(c) Hospital or institution:

union memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Aberdeen, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 403 Lorraine St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Wesley Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1931

8. AGE: Years Months Days If less than one day

11 8 24 25 hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Mrs Webb Jones

13. Birthplace Virginia

14. Maiden Name Jane Le Sage

15. Birthplace Washington D.C.

16 (a) Informant Mrs Webb Jones

(b) Address 403 Lorraine St. Aberdeen, Md.

17 (a) Burial (b) Date thereof Aug. 24, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Byker's Green

18 (a) Funeral director

(b) Address Aberdeen, Md.

19 (a) 8/22/43 (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21-43 19 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1943. to Aug 21 1943. and that I last saw him alive on Aug 21 1943.

Immediate cause of death cardiac-respiratory failure

Due to Intestinal obstruction

Due to Peritoneal adhesions

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Intestinal obstruction

of autopsy: Intestinal obstruction in peritoneum

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Hart Jr. M.D.

Address Union Memorial Hosp. Date signed 8-24-43

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07433

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3322 Rueckert Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3322 Rueckert Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Florence Buttner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Fred J. Buttner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-1889

8. AGE: Years Months Days If less than one day

53

9

9

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name John M. Wagner

13. Birthplace Baltimore

14. Maiden Name Mary Jane Miller

15. Birthplace Baltimore

16 (a) Informant Fred J. Buttner

(b) Address 3322 Rueckert Ave

17 (a) Burial (b) Date thereof 8-21-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Hayford Road

19 (a) 8/22/43 (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1940 to July 30 1943 and that I last saw him alive on July 30 1943.

Immediate cause of death

Cerebral hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Francis L. Doyle M.D.

Address 6077 Hayford Rd Date signed 8/19/43

Duration

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07434
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 904 Sarah Ann St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lottie Queen

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Widow

6 (b) Name of husband or wife Guy Queen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/1895

8. AGE: Years Months Days If less than one day

48

2

7

hr.

min.

9. Birthplace Annapolis, Md.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name Theodore Scott

13. Birthplace Md.

14. Maiden Name Martha Brown

15. Birthplace Md.

16 (a) Informant Mary Wooden

(b) Address 409 N. Poppleton St.

17 (a) (b) Date thereof (month) (day) (year)

(Burial, cremation, or removal)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Katie R. Williams

(b) Address 522 N. Scholcher St.

19 (a) (b) (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1943 11:30 AM

21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH

Hypertensive Cardia-
vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

Signature 26 Hugh B. McCallum

Medical Examiner

Date signed 8/18/43

G 07435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07435

Registered No.

54a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Street

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yes, month, as days) 11

(e) Length of stay in Baltimore (yes, month, as days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn. (b) County

(c) City or town Woodbine, Pa. R.D. #1
(If outside city or town limits, write RURAL and give town)(d) Street No. R.D. #1
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MR. JOHN ROY KENNEDY

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Frieda Kennedy

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 16, 1911

8. AGE: Years Months Days If less than one day

32

2

5

hr.

min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

12. Name Samuel Kennedy

13. Birthplace Pennsylvania

14. Maiden Name Emily Michael

15. Birthplace Pennsylvania

16 (a) Informant Mrs. John R. Kennedy

(b) Address Woodbine, Penn. R.D. #1

17 (a) (b) Date thereof Aug. 24/43

(Burial, cremation, or removal) in (month, day, year)

(c) Cemetery or crematory Mt. Kenilworth Mch. Cem.

Location Stewart & Mowen Company

18 (a) Funeral director

(b) Address 108-W North Ave, City

19 (a) (b)

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1943, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1943 to Aug. 21 1943, and that I last saw him alive on Aug. 21 1943.

Immediate cause of death

Cardio-Respiratory failure.

Due to

Glioma of brain

Due to

Right frontal lobe.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/18/43, 8/20

Major findings of operations: Glioma of brain

Rt. frontal lobe

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Kennedy, Jr.

Address Union Memorial Hospital Date signed 8-21-43

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07436
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married/widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

AUG 22 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from to
and that I last saw him alive onImmediate cause of death
Due to

Due to

Other Conditions

(Include pregnancy within 1 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 year

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07437

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33rd St

(c) Hospital or institution:

Union Mem. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. Raymond Arthur Nichols

3 (b) If veteran, name was

None

3 (c) Social Security Account

No. 717-07-7416

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Michael Nichols

6 (c) If alive, give age

60 years

7. Birth date of deceased (mo., day, yr.)

Feb-13-1885

8. AGE:

Years

Months

Days

If less than one day

58

6

8

hr.

min.

9. Birthplace

Utica, N.Y.

(Town, county, and state)

10. Usual Occupation

Bank

11. Industry or business

Bank N.Y.

12. Name

Mr. R. Nichols

13. Birthplace

New York

14. Maiden Name

Marie J. Gering

15. Birthplace

Utica, N.Y.

16 (a) Informant

Mr. R. Nichols

(b) Address

3326 Elmwood Ave

17 (a)

Burial

(b) Date thereof

Aug 24 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore, Md.

18 (a) Funeral director

Baltimore, Md.

(b) Address

1234 N. Charles St.

19 (a) Registrar

William M. St.

20 (a) Registrar

William M. St.

21 (a) Registrar

William M. St.

22 (a) Registrar

William M. St.

23 (a) Registrar

William M. St.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-21

1943

at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1943 to 8-21 1943.

and that I last saw him alive on 8-21 1943.

Immediate cause of death

Coronary Bypass

Duration

Fulminant

Due to

Carcinoma of Rectum

Due to

metastases

Due to

Old Lymph Node & Liver

Other Conditions

Arteries, Jaundice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

Lawson J. T.

Address

Union Mem. Hosp.

Date signed 8-24-43

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AUG 23 1943

VB 150

G 07438

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07438

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address SINAI HOSPITAL

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 914 Fell Street

(If rural, give location)

(e) Citizen of foreign country No

(Yes or No)

If yes, name country

3 (a) FULL NAME

MARY ZIENTAK

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

Married

6 (b) Name of husband or wife Theodore

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 10, 1889

8. AGE: Years

Months

Days

If less than one day

54

3

9

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name John Superczynski

13. Birthplace Poznan, Poland

14. Maiden Name Julianna Chyminska

15. Birthplace Poznan, Poland

16 (a) Informant Mr. Theodore Zientak

(b) Address 914 Fell Street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/23/43

(month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons

(b) Address 1808 Eastern Ave

AUG 22 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19

1943 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1943 to 8/19 1943.

and that I last saw him alive on 8/19 1943.

Immediate cause of death Pulmonary Edema

Duration

Due to Corb. Acc

Due to Hypertensive CVD.

Other Conditions Corb. p.p.t. + Pul. E.

Rt. + Lt. Ventr. Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 8/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07439

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) P. U. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 631 W. Conway St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Alexander Simpkins

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1888

8. AGE: Years Months Days If less than one day

85

5

12

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Joseph Simpkins

13. Birthplace Annapolis, Md.

14. Maiden Name Mae?

15. Birthplace Annapolis Md.

16 (a) Informant Joseph Simpkins

(b) Address 602 N. Fremont Ave.

17 (a) Burial (b) Date thereof Aug 22-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St.

19 AUG 22 1943 (month) (day) (year) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1943, at 8:30 P.

21. I certify that I took charge of the remains described above, held an
thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Extensive coronary
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed August 19 1943
Medical Examiner.

G 07440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07440

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 932 Bennett Place
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.4 Sex Female 5. Color or race Negro 6 (a) Single, married, widowed, or divorced M6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22-948. AGE: Years 48 Months 8 Days 26 If less than one day
hr. min.9. Birthplace Balto., Md.
(Town, county, and state)10. Usual Occupation House wife

11. Industry or business

12. Name Phillip Thomas Gross13. Birthplace Balto., Md.14. Maiden Name Adeline Dorell15. Birthplace Balto., Md.16 (a) Informant Mr. Robert Edwards(b) Address 932 Bennett Pl.17 (a) Burial (b) Date thereof 8-22-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutus MemLocation Arbutus Md.18 (a) Funeral director Mrs. Ruth A. Williams(b) Address 322 N. Schroeder St(c) Date rec'd by registrar Aug 22 1943(d) Signature Harry J. Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1943 12 p.m.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1943 to Aug 18 1943, and that I last saw him alive on Aug 18 1943.Immediate cause of death Coronary Occlusion

Due to

Due to

Other Conditions Diabetes Mellitus
Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury Car23. Signature G. J. Barfield M. D.Address Providence Hospital Date signed 8-19-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Contact age is especially important.

G 07441

Tomlin
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07441

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name/war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

56

2

7

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Reuben Moore

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 22 1943

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10, 1943, to Aug 18, 1943, and that I last saw him alive on Aug 16, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07442

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 3135 Oakford Ave.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore City.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3135 Oakford Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mary E. McGovern.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife. Albert J. McGovern
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1877

8. AGE: Years 65 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Penna.
 (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

12. Name Cornelius Myers

13. Birthplace Ireland

14. Maiden Name Johanna Barry

15. Birthplace Ireland

16 (a) Informant Francis D. Brown,

(b) Address 3135 Oakford Ave.

17 (a) Burial (b) Date thereof 8/23/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
 Location Baltimore City

18 (a) Funeral director G. Kernan Lerman

(b) Address 4611 Park Heights Ave.

AUG 22 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1943, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Aug. 20, 1943, and that I last saw her alive on Aug. 20, 1943.

Immediate cause of death

Generalized Carcinomatosis

Duration

2 yrs.

Due to

Carcinoma of Cervix of Uterus

3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature G. Kernan Lerman M.D.

Address 1101 N. Fulton Ave. Date signed 8/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07443

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.2.43

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1630 Benhill Avenue
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anthony J. Mackiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1889

8. AGE:

Years

Months

Days

If less than one day

54

7

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Felix Mackiewicz

13. Birthplace

Poland

MOTHER

14. Maiden Name

Annie (Unknown)

15. Birthplace

Poland

16 (a) Informant

Vincent Mackiewicz

(b) Address

Sandwich, Pa.

17 (a)

Burial

(b) Date thereof

8/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Resurrection

Location

Baltimore, Md.

18 (a) Funeral director

William C. Cook, Inc.

(b) Address

1217 St Paul St

19 (a)

AUG 23 1943

Huntington Williams

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1943 at 5 P. M.

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Asphyxiation
due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury Unknown M.

(b) Where did injury occur? near Benhill St

(c) Did injury occur at home, on farm, industrial place, in public
place? words While at work? No

(d) Means of injury Hanged by rope

23. Signature

Robert L. Graham M.D.

Date signed

August 21 1943

G 07444

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07444

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
Not

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

County

(c) City or town

(If outside city or town, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 21 1943. 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1943, to 8/21 1943, and that I last saw him alive on 8/21 1943.

Immediate cause of death

Respiratory failure

Due to

Pneumonia
or atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Josephine E. Renshaw

Address

Univ. Hosp.

Date signed 8/21

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07445

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

AUG 23 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

at 8:15 A

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Aug 21 1943.

and that I last saw him alive on Aug 11 1943

Immediate cause of death

Coronary disease

Due to

Hypertensive
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Jack J. Singer

Address 506 E. North Ave

Date signed

AUG 23 1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07446

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date of death

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 22 1943. 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 8/13/43 19 to 8/22 1943

and that I last saw him alive on 8/22 1943.

Immediate cause of death Ray. Failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Brain clots

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 8/22/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

AUG 23 1943

G 07447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 07447
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1329 N. Eden St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1329 N. Eden St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account
No. 212-09-7088

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) June 26, 1883

8. AGE: Years Months Days If less than one day

60

1

16

26

hr.

min.

9. Birthplace

Baltimore Md.

10. Usual Occupation

Salesman

11. Industry or business

Horseshoe Quality

FATHER
MOTHER

12. Name

John F. Plantholt

13. Birthplace

Baltimore Md.

14. Maiden Name

Dress Albert

15. Birthplace

Surrey

16 (a) Informant

Minnie Plantholt

(b) Address

1329 Eden St.

17 (a)

Burial

(b) Date thereof

8/25/43

(Burial, cremation, or removal)

(c) Cemetery or cremation

Holy Cross

Location

Baltimore Md.

18 (a) Funeral director

Thorn Coal Co.

(b) Address

1214 St Paul St.

19 (a)

August 23, 1943

(b) Registrar

for William M. R.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1943, at 6²⁰ P.M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

occlusion

Coronary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert A. Graham M.D.

Date signed

August 22, 1943

G 07448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07448

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

(b) Date of death

(c) Date of death

(d) Date of death

(e) Date of death

(f) Date of death

(g) Date of death

(h) Date of death

(i) Date of death

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

1943

1943

1943

1943

1943

1943

1943

1943

1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07449

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1125 E. 20th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1125 E. 20th St (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Minnie Knight

3 (b) If veteran, name war

M

3 (c) Social Security Account

No. NONE

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife John A. Knight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1871

8. AGE: Years 72 Months 6 Days 12 hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At home

12. Name Charles Seixen

13. Birthplace Germany

14. Maiden Name Caroline Newwiler

15. Birthplace Md.

16 (a) Informant John A. Knight

(b) Address 2031 E. 32nd St

17 (a) Burial (b) Date thereof 8/24/43
(Burial, cremation, or disposal) (month) (day) (year)

(c) Cemetery or crematory Balto

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 1343 St Paul St

19 AUG 23 1943 (b) Trusting for Baltimore, Md

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21st 1943, 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4, 1940, to Aug 21, 1943, and that I last saw her alive on Aug 20, 1943.

Immediate cause of death Chronic Myocarditis

Duration 3 yrs.

Due to

Due to

Other Conditions Dilated Atherosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Wolfe

Address 1331 E. North Ave

Date signed 8-24-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07450

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1511 E Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

3 (a) FULL NAME

3 (b) If veteran, name and

3 (c) Social Security Account

No. 212-10-9991

4. Sex

Male

5. Color of face

White

6 (a) Single, married, widowed, or

divorced Married

6 (b) Name of husband or wife

Marg E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 20, 1900

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

St Marys Co Md

10. Usual Occupation

Shipping Clerk

11. Industry or business

May Co. Business

12. Name

William Longford

13. Birthplace

Md

14. Maiden Name

Emma

15. Birthplace

Md

16 (a) Informant

Mary E Longford

(b) Address

1511 E Lafayette Ave

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

8/24/43

(c) Cemetery or cremation

Holy Redeemer

18 (a) Funeral director

William Longford

(b) Address

St Paul St

19 AUG 23 1943

(b) Issued by Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(c) City or town

Baltimore

(d) Street No.

1511 E Lafayette Ave

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 21, 1943, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug 16, 1943, to Aug 21, 1943,

and that I last saw him alive on Aug 21, 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Samuel B. Wolf

Address

1331 S. North Ave

Date signed 8-24-43

Duration

5 days

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07452

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1412 Homestead st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 58 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Ida Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1948

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name Alfred Taft

13. Birthplace N.Y.

14. Maiden Name Laura Brown

15. Birthplace N.Y.

16 (a) Informant Warren W. Brown

(b) Address 1400 Homestead st

17 (a) Burial (b) Date thereof 8/23/43 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st.

19 (a) Date of death 8/23/43 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County City

(c) City or town Balto

(d) Street No. 1412 Homestead st (If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4/43, Aug 21/43 and that I last saw him alive on 8/21/43

Immediate cause of death Myocardial Infarction

Due to Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature + J. H. Harrington

Address 1710 E 33rd St

Date signed 8/22/43

M. D.

43

AUG 23 1943

VB 136

G 07453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07453
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town

Hampstead (Rural)

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mannie M. Maxmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Charles V. Maxmore

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec 2 - 1883

8. AGE: Years 59 Months 8 Days 20 hr. min.

9. Birthplace

Maryland

10. Usual Occupation

Housewife

11. Industry or business

own home

12. Name

Geo H. Cameron

13. Birthplace

Virginia

14. Maiden Name

Mary Shunk

15. Birthplace

Maryland

16 (a) Informant

Mrs Marshall Bishop

(b) Address

Hampstead Md

17 (a) Burial

(b) Date thereof Aug 24/43

(c) Cemetery or crematory

Paul Grove

Location

Route 50

18 (a) Funeral director

Edw. E. Dutton

(b) Address

Hampstead Md

19 (a) AUG 23 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1943 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1943 to 8/22 1943, and that I last saw her alive on 8/22 1943.

Immediate cause of death

Melanotic Carcinoma of epidural space -

Due to

Bronchiogenic Ca.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Melanotic

Carcinoma of spine.

of autopsy: Same

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Ruth

Address

Univ. Hosp.

Date signed 8/23

G 07454

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07454
Registered No.

B3321

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mo., or days) 3 days

(e) Length of stay in Baltimore (yrs., mo., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 62 S. Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

John Forsythe

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15 1889

8. AGE: Years

54

Months

7

Days

6

If less than one day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation ? Painter

11. Industry or business

FATHER

12. Name George Forsythe

13. Birthplace Md.

MOTHER

14. Maiden Name Dorothy Akerman

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 9, 25, 1943

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

AUG 23 1943

Registrar

John Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8 / 21 1943, 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/15 1943 to 8/21 1943
and that I last saw him alive on 8/21 1943

Immediate cause of death

Anemia

Due to

Post. chm. glomerular
nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. J. Sargman
BCH Date signed 8/21

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07455

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 Greenwillow St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

46

Months

Days

If less than one day

hr.

min.

9. Birthplace

Petersburg Va.

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

12. Name

George Bowles

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Alberta Richardson

(b) Address

507 Greenwillow St.

17 (a) Burial

(b) Date thereof 8/25/43.

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Balto. National

Location

Adolphus Hall

18 (a) Funeral director

Adolphus Hall

(b) Address

918 Druid Hill Ave.

19 (a)

AUG 23 1943

(b)

(Date)

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1943, at 2:58 M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 19 1943 to Aug 21 1943, and that I last saw him alive on Aug 21 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age in subsequent important statements. Physicians: please write the cause of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07456
83070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1370 ✓ G 07456
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) **15 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **50 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **406 McMechen St.**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME

James Brooks

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Separated

6 (b) Name of husband or wife **Lovaleen Brooks ?**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Mar. 7, 1893**

8. AGE: Years Months Days If less than one day

50

5

14

hr.

min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation **Shipping Clerk**

11. Industry or business

12. Name **Henry Brooks**

13. Birthplace **?**

14. Maiden Name **Lina ?**

15. Birthplace **Md.**

16 (a) Informant **Baltimore City Hospitals**

(b) Address **(Records)**

17 (a) **Burial** (b) Date thereof **8-21-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn Cem**
Location **Baltimore, Md.**

18 (a) Funeral director **Mr. Francis A. Hunsley**

(b) Address **578 W. Biddle St.**

19 (a) (b)

(Date rec'd by registrar)

Registrar

AUG 23 1943

Hunting for Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-21-43** **3:30 PM**

21. I certify that death occurred on the date above stated; that I attended
deceased from **8-6** **1943** to **8-21** **1943**
and that I last saw **him** live on **8-21** **1943**.

Immediate cause of death

Uremia
Due to **Pyelonephritis**

Due to **Benign Prostatic**
hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Donald B. Selt**

Address **Baltimore City Hosp** Date signed **8-23-43**

Duration

100
2 wks

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

RECORDS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07457

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 302 S. Washington St.

(c) Hospital or institution

Lian Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 302 S. Washington St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emil Reda Jr.

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14-1943

8. AGE: Years Months Days If less than one day

2 7 hr. min.

9. Birthplace Baltimore-Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Emil Reda

13. Birthplace Baltimore Md.

14. Maiden Name Tekness Corridi

15. Birthplace Baltimore Md.

16 (a) Informant Emil Reda Jr.

(b) Address 302 S. Washington St.

17 (a) Burial (b) Date thereof Aug-23-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore Md.

18 (a) Funeral director F. W. Ozagowski

(b) Address 1930 Eastern Ave

19 (a) (b)

(Date rec'd by registrar) (Signature)

AUG 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1943, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1943, to 8/21 1943, and that I last saw him alive on 8/21 1943.

Immediate cause of death

Pneumonia - cause & etiology unknown.

Due to

infectious agent to follow

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Report to follow

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald W. Winkler

Address 1101 11th St Date signed 8/22

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07458
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

0 hr. 27 min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 23 1943

G 07459

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07459
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

752 Melville Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

752 Melville Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Year

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 22 1943, at 9 P M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Asphyxiation
due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Aug. 22 1943 11 A M.

(b) Where did injury occur?

752 Melville Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? home

While at work? no

(d) Means of injury

Hanged self with rope

23. Signature

Robert Lee Ginter, M.D.

Medical Examiner

Date signed

Aug. 22 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07460

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.A. Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2416 Madison Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Dorothy Nixon

3 (b) If veteran, name war

3 (c) Social Security Account

No. nm

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or

Married

6 (b) Name of husband or wife

Luther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 14, 1895

8. AGE:

Years

Months

Days

If less than one day

48

86

5

hr.

min.

9. Birthplace

Northumberland Co. Pa.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Octavia Bea

13. Birthplace

Virginia

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Luther Nixon

(b) Address

2416 Madison Ave.

17 (a)

Burial

(b) Date thereof

Aug. 27, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Int. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

Mr. Geo. W. Hill

(b) Address

1631 Prind Hill Ave.

19 (a)

AUG 23 1943

Washington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/19

1943, 10:45 PM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

Means of injury

Signature

Hugh B. McMillan

Date signed

8/20/43

Medical Examiner.

correct age is especially important. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly.

07461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 07461
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John Cook

3 (b) If veteran, name was

3 (c) Social Security Account
No. 215-05-5296

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Theresa V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1898

8. AGE: Years Months Days

44 45

108

8 22

If less than one day

hr.

min.

9. Birthplace

Annapolis, Md.

10. Usual Occupation

Laborer

11. Industry or business

Ship Building

12. Name

Joseph Cook

13. Birthplace

Broadneck, Md.

14. Maiden Name

Rachel Johnson

15. Birthplace

Eastern Shore, Md.

16 (a) Informant

Theresa V. Cook

(b) Address

2453 Francis St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 24, 1943

(c) Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18 (a) Funeral director

Mr. George H. Waller

(b) Address

1631 David Hill Ave.

19 AUG 23 1943

Dr. William H. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(d) Street No.

2453 Francis St.

(e) Citizen of foreign country

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20

1943, at 8:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1943, to Aug 20 1943, and that I last saw him alive on Aug 20 1943.

Immediate cause of death

Lobar Pneumonia (Right)

Due to

Due to

Other Conditions

Acute Hepatitis Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

W. H. Williams

Address

Provident Hospital Date signed 8-20-43

Duration
16 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161c G 07462

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* St. *14* Ward)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME *Infant of Alice & Joseph Youngbar* YOUNGBAR(a) Residence: No. *Franklin Square Hospital* St. *3706* Ward. *9th St Brooklyn*
(Usual place of residence) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>F.</i>	4. Color or Race <i>W.</i>	5. Single, Married, Widowed, or Divorced (write the word) <i>Infant</i>
6. If married, widowed, or divorced HUSBAND of (or) WIFE of		
7. DATE OF BIRTH (month, day, year) <i>8/20/43</i>		
7. AGE	Years	Months
		Days
		If LESS than 1 day 8 hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (city or town) (State or country) <i>Baltimore</i>		
13. NAME <i>Joseph S Youngbar</i>		
14. BIRTHPLACE (city or town) (State or country) <i>Baltimore</i>		
15. MAIDEN NAME <i>Alice Kasper</i>		
16. BIRTHPLACE (city or town) (State or country) <i>Baltimore</i>		
17. INFORMANT <i>Mother Joseph Youngbar</i> (Address) <i>3706-9th St - Brooklyn</i>		
18. BURIAL, CREMATION, OR REMOVAL <i>Holy Cross AARO Aug. 23, 1943</i>		
19. UNDERTAKER <i>Bernard G. Harbo</i> (Address) <i>31 E. North St.</i>		
20. FILED <i>AUG 23 1943</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *8/20/43*, 19 *43*

22. I HEREBY CERTIFY, That I attended deceased from *8/20* 19 *43* to *8/20* 19 *43*

I last saw *her* alive on *8/20* 19 *43* Death is said to have occurred on the date stated above, at *10:00 p.m.*

The principal cause of death and related causes of importance were as follows:

unknown post-delivery death.

Date of onset

8/20/43

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) *W. K. Moore* M. D.
(Address) *Franklin Square Hospital*

G 07463 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 83a

G 07463

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S Linwood Ave Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

(a) Residence: No. 802 S Linwood Ave

(Usual place of abode)

Ward

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. Color or Race *W* 5. Single, Married, Widowed, or Divorced (write the word) *Widower*

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of *Mamie*

7. DATE OF BIRTH (month, day, year) *1858*

7. AGE Years Months Days If LESS than 1 day, hrs. or min. *85*

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Labor*

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) *Baltimore Md*

13. NAME ?

14. BIRTHPLACE (city or town) (State or country) ?

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT *Mamie E Riegel*(Address) *802 S Linwood Ave*

18. BURIAL, CREMATION, OR REMOVAL

Place *Mt Carmel*Date *8-23*19 *43*19. *AUG 23 1943*

20. FILED

15

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *Aug 20* 19 *43*22. I HEREBY CERTIFY. That I attended deceased from *Aug 8* 19 *43* to *Aug 20* 19 *43*I last saw him alive on *Aug 20* 19 *43* Death is said to have occurred on the date stated above, at *10:15 P.m.*

The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy
Bronchial Pneumonia

Date of report *8/24/43**4/18/43*

(Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so specify

(Signed)

(Address)

Geo. M. Bismyander M. D.
Baltimore Md

OCCUPATION is very important. See instructions on back of certificate.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07464

GLASSNER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

460 ✓
G 07464
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Sanatoga & Calvert.*

(c) Hospital or institution: *Mercy Hosp.*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *6 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *2125 E. Fairmount Ave*
(If rural give location)

(e) Citizen of foreign country? *(Yes or No)*
If yes, name country

3 (a) FULL NAME *William B. Glassner*

3 (b) If veteran, name war

3 (c) Social Security Account No. *210-09-9731*

4. Sex *M*

5. Color or race *W*

6 (a) Single, married, widowed, or divorced *M*

6 (b) Name of husband or wife *Lillian Glassner*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 6-1899*

8. AGE: Years *44* Months *2* Days *15*
If less than one day hr. min.

9. Birthplace *West Virginia*
(Town, county, and state)

10. Usual Occupation *Laboer*

11. Industry or business *Emtery work*

FATHER

12. Name *Christia Glassner*

13. Birthplace *West Virginia*

MOTHER

14. Maiden Name *Sarah C. Comer*

15. Birthplace *West Virginia*

16 (a) Informant *Mrs. Lillian Glassner*

(b) Address *2125 E. Fairmount Ave*

17 (a) *Burial* (b) Date thereof *8 24 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Carmel*
Location *Baltimore*

18 (a) Funeral director *Philip Herwig Sons*

(b) Address *2024 Orleans St.*

20. DATE OF DEATH *August 21 1943. at 12³⁰ PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug. 16 1943.* to *Aug. 21 1943* and that I last saw him alive on *Aug. 21 1943.*

Immediate cause of death *remia*

Due to *Metastatic Carcinoma*

Due to *(over)*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *(Specify type of place)* While at work?

(e) Means of injury

23. Signature *J. R. English* M. D.

Address Date signed *8/21/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 23 1943

213

VS 150

G 07465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH119a G 07465
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1518 Thames

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1518 Thames St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Angelina Kokinos

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9 '438. AGE: Years Months Days less than one day412

hr.

min.

9. Birthplace

Balto MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Gus Kokinos

13. Birthplace

Greece

14. Maiden Name

Clara Schmidt

15. Birthplace

Balto MD

16 (a) Informant

Flora Kokinos

(b) Address

1518 Thames St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8 23 43

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Balto

18 (a) Funeral director

James J. Brydzinski

(b) Address

1407 Eastern Ave. Eves

19 (a)

(by registrar)

(b)

Theresa J. M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1943 at P M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1943 to Aug 19 1943, and that I last saw him alive on Aug 19 1943.

Immediate cause of death

Diarrhea
Dehydration

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Chas. D. Lippert

Address

1212 Patterson Pl

Date signed

M. D.

8/21/43approved by Harold J. Muesing, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 23 1943

21

G 07466
82774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07466

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4001 Liberty Heights Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward A. Jones

3 (b) If veteran, name war none

3 (c) Social Security Account No. 176-18-9029

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1882

8. AGE: Years Months Days If less than one day

60

8

20

hr.

min.

9. Birthplace Md. (Baltimore)

(Town, county, and state)

10. Usual Occupation Unable to work

11. Industry or business Painter

12. Name Joseph E. Jones

13. Birthplace Md.

14. Maiden Name Mary Dunn

15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Cremation (b) Date thereof Aug. 23, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Crematory

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 23 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.20 1943 at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7.21 1943 to 8.20 1943, and that I last saw him alive on 8.20 1943.

Immediate cause of death

Gen. Peritonitis
Ate of Organ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald B. Nick
Address Balto City Hosp signed 8/21/43

Duration

8 M.O

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians, please see instructions on page 1.

G 07467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07467

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 18 N. Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BERTHA AMELIA SWEENEY

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife James B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1884

8. AGE:

Years

Months

Days

If less than one day

58

11

10

hr.

min.

9. Birthplace York Co., Pa.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Noah F. Winemiller

13. Birthplace York Co., Pa.

MOTHER

14. Maiden Name Josephine Lamison

15. Birthplace York Co., Pa.

16 (a) Informant Mr. James B. Sweeney

(b) Address 18 N. Highland Ave.

17 (a) Burial (b) Date thereof 8/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Shrewsbury, Pa.

Location

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address 18 N. Highland Ave.

19 (a) AUG 23 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/43 to 8/20/43 and that I last saw her alive on 8/19/43.

Immediate cause of death

Carcinoma Lung

Duration

4 mos

Due to

Carcinoma Breast 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

Means of injury

23. Signature

L. N. Haysman

Address 1710 E 32 St

Date signed 8/22/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07468

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 806 Powers St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph S. Carrick

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Lula E.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1877

8. AGE:

Years

Months

Days

If less than one day

65

9

5

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

FATHER

12. Name Joseph Carrick

13. Birthplace Md.

MOTHER

14. Maiden Name Marietta Nicholson

15. Birthplace Md.

16 (a) Informant Lula E. Carrick

(b) Address 806 Powers St.

17 (a) Burial (b) Date thereof Aug 24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Stephen's

Location Hayford Co. Md.

18 (a) Funeral director Chenoweth & Donovan

(b) Address 3615-N E. Lexington Ave

AUG 23 1943

VB 144

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1943, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1943, to Aug 21 1943, and that I last saw him alive on Aug 21 1943.

Immediate cause of death Cachexia & Septic insufficiency

Due to Melanoma of liver

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address St. Agnes Hosp. Date signed 8/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07469

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3706 Forest PK Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write R.R. and give town)

(d) Street No. 3706 Forest PK Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MOSES SLOSSBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Helvete

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

62 6 2

If less than one day

hr. min.

9. Birthplace

Lith

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Isaac Slossberg

13. Birthplace

Lith

14. Maiden Name

Yetta

15. Birthplace

Lith

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof 8-28-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Wynona Hill Rd

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

(Date rec'd by registrar)

AUG 23 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23-43 19 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943, to Aug 23, 1943, and that I last saw him alive on Aug 22, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1720 Buthol Date signed 8/28/43

Duration

9 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07470

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LENA GOODMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/23

1943, at 2:11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1943 to 8/23 1943.

that I last saw him alive on 8/23 1943.

Immediate cause of death

Pulmonary edema

Duration

Due to

Pneumonia

Due to

Hypertensive Ht. dis.

Other Conditions

Left iliac thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07471
80608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07471
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **4mo. 27d**
(e) Length of stay in Baltimore (yrs., mos., or days) **56 yrs**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **4925 Eastern Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Gray

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife **Bridgett Kehoe (D)**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 24, 1869**

8. AGE: Years Months Days If less than one day
73 7 26 25 hr. min.

9. Birthplace **Ireland**
(Town, county, and state)

10. Usual Occupation **Supported by D. P. W.**

11. Industry or business

12. Name **John**

13. Birthplace **Ireland**

14. Maiden Name **Catherine**

15. Birthplace **Ireland**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **Aug-23-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Sacred Heart**
Location

18 (a) Funeral director **John B. Connolly**

(b) Address **418 Eastern Ave**

19 (a) **Huntington Williams, M.D.** (b) Address **Balto City, Md**

AUG 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-19-43** at **11:15 PM**

21. I certify that death occurred on the date above stated; that I attended
deceased from **5-27-43** to **8-19-43**
and that I last saw him alive on **8-19-43**

Immediate cause of death

Carcinoma of Rectum

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation **4-5-43**

Major findings of operation:

Above

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature **Ronald B. Webb** M. D.

Date signed **8-20-43**

Duration

1 1/2 yrs

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07472

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1609 Linden Avenue

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Bertha M. Kroth

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

John J. Kroth

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1895

8. AGE: Years Months Days If less than one day

48 2 2 hr. min.

9. Birthplace Hopewell Va

(Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business Harris Dress Co.

12. Name Richard Sherbert

13. Birthplace Don't know

14. Maiden Name Elizabeth Schickel

15. Birthplace Balto Md

16 (a) Informant John J. Kroth (Husband)

(b) Address 1411 Olive St

17 (a) Burial (b) Date thereof Aug 24, 1943

(c) Cemetery or crematory Glen Beach Pk

Location Anne Arundel Co Md

18 (a) Funeral director A. W. Evans

(b) Address 1400-06 S. Harbor St

19 (a) AUG 23 1943

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1943, at 10 A.M.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Stat wound

of vagina

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury August 21, 1943 7 AM

(b) Where did injury occur? 1609 Linden Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? Home While at work? No

(d) Means of injury sharp instrument

23. Signature Robert L. Fratom M.D.

Date signed August 21, 1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07473
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town 2910 Garrison Blvd
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof 8-23-1943
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1943, at 4 P M21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Chronic myocardial
degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Date signed August 21, 1943

M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 23 1943
VS 151Huntington Williams, M.D.
Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07474

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1941

8. AGE: Years 1 Months 19 Days min.

9. Birthplace Balto. Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Willie Phammas

13. Birthplace

14. Maiden Name Mary Fleet

15. Birthplace

16 (a) Informant Mary Phammas

(b) Address 1118 W. Franklin St.

17 (a) Burial (b) Date thereof 8-28-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 W. Schroeder St.

19 (a) Registrar (b) Huntington Hill, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1118 W. Franklin St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1943. 2:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Aug 19 1943, and that I last saw him alive on Aug 19 1943.

Immediate cause of death

Purpura hemorrhagica
Due to

Due to

Other Conditions Secondary Anemia
malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature G. L. Banfield M. D.

Address Provident Hospital (Date signed 8-19-43)

G 07475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07475

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 821 N. Fremont Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Poinclafte Newton

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 30, 1919

8. AGE:

Years

Months

Days

If less than one day

44

1

19

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER12. Name Alexander Newton13. Birthplace Arlington Co., Va.14. Maiden Name Lelia Carnish15. Birthplace Baltimore, Md.16 (a) Informant Catherine Newton(b) Address 821 N. Fremont Ave.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Aug 24-43

(month, day, year)

(c) Cemetery or crematory National Cem

Location

18 (a) Funeral director Mrs Kate P. Williams(b) Address 322 N. Schenck St19 (a) AUG 23 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-19-1943, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Muller M.D.

Medical Examiner.

Date signed 8-20-43

G 07476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07476

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 925 W. Saratoga St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

William Davadge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1863

8. AGE: Years

80

Months

Days

If less than one day

hr.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

unknown

13. Birthplace

14. Maiden Name

unknown

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

Aug. 25-43
(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

3228 Schaeffer St

19 (a)

AUG 23 1943
(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1943, at 10:40 AM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

Did injury occur at home, on farm, industrial place, in public place? While at work?

(c) Means of injury

23. Signature Robert L. Fisher M.D.

Date signed August 21, 1943

correct age is especially important. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07477

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Sinai Hospital**
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3724 Cottage Ave**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Pearl Kantor

3 (b) If veteran, name war

3 (c) Social Security Account
No. **213-01-7310**

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife

Late Marks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **April 10, 1891**

8. AGE: Years **52** Months **4** Days **12**
If less than one day hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business **Tailor Examiner**

FATHER
MOTHER

12. Name **Isaac Sugar**

13. Birthplace **Poland**

14. Maiden Name **Rachel Sulsky**

15. Birthplace **Poland**

16 (a) Informant **Mrs Belle Meinster**

(b) Address **3521 Risterstown Road**

17 (a) **Burial** (b) Date thereof **August 24, 1943**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Hebrew Washington Road**

Location **Halethorpe Md**

18 (a) Funeral director **Sol Levinson & Bros**

(b) Address **1124 1126 W North Ave**

AUG 23 1943

(Date rec'd by registrar)

William M. R.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8/22** 1943 at **11:50 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **8/22** 1943 to **8/22** 1943 and that I last saw him alive on **8/22/1943**

Immediate cause of death

Pneumonia

Due to

curious of ucto - Sigmoid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **W. Wachmann**

Address **Sinai Hospital** Date signed **8/22**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07478
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1427 N. Bruce Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1427 N. Bruce Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Oella Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1890

8. AGE: Years Months Days If less than one day

52 8 10 11 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name William Powell

13. Birthplace Md.

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Seay Crawford(b) Address 1427 N. Bruce Street17 (a) Burial (b) Date thereof 8/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. AuburnLocation Md.18 (a) Funeral director Mrs. G. Nelson(b) Address 1313 Presbiterian StAUG 23 1943 Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-1943 at 8:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Thomas J. Wallace M.D.Date signed 8/20/43

Medical Examiner.

THE
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07479

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07479
Registered No. 3698

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1701 Division St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

3 (a) FULL NAME

Mary Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

James Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1880

8. AGE: Years Months Days If less than one day

62 11 10 hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant James Taylor Jr

(b) Address 1701 Division St.

17 (a) 8/24/43 Date thereof Burial (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Md

18 (a) Funeral director Geo. G. Nelson

(b) Address 1803 Pressingway

19 AUG 23 1943 (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1701 Division St.

(e) Citizen of foreign country? no (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-1943, at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29-1943 to 8-20-1943, and that I last saw her alive on 8-20-1943.

Immediate cause of death

Cerebral thrombosis

Due to nephritis, hypertension, and arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank A. Saunders M. D.

Address 1029 N. Strickland St. Date signed 8-20-43

Duration 9 hours

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

07480

HEALTH DEPARTMENT—CITY OF BALTIMORE

07480

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 523-Tunbridge Rd. Ward) ✓108Length of residence in city or town where death occurred 29 yrs. How long in U. S. If foreign birth? 8 yrs. 10 mos. 10 ds.2. FULL NAME Alice Augusta Shields(a) Residence: No. 523-Tunbridge Rd. St. V Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U. S. Veteran specify WAR _____

PERSONAL AND STATISTICAL PARTICULARS

3. Sex H. 4. Color or Race W 5. Single, Married, Widowed, or Divorced (write the word) Widow6a. If married, widowed, or divorced, name of (or) WIFE of Delmond D. Shields6. DATE OF BIRTH (month, day, year) Jan. 21-18697. AGE Years 74 Months 5 Days - If LESS than 1 day, hrs. - or min. -8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____12. BIRTHPLACE (city or town) (State or country) Ind.13. NAME Benj H. Shields14. BIRTHPLACE (city or town) (State or country) Ind.15. MAIDEN NAME Augusta Morrison16. BIRTHPLACE (city or town) (State or country) Ind.17. INFORMANT Joseph P. Pitt (Address) 523 Tunbridge Rd.18. BURIAL, CREMATION, OR REMOVAL Place Ind. Office Date 5/24/4119. UNDERTAKER (Address) J. J. Baker20. DATE OF DEATH AUG 23 1943 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 8/21/4322. HEREBY CERTIFY, That I attended deceased from July 31, 1943 to Aug. 21, 1943 last saw her alive on Aug. 21, 1943 Death is said to have occurred on the date stated above, at 3 P.M.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia 9 days
Endocarditis 10 days

Other contributory causes of importance: _____

Was an operation performed? NO Date of _____

For what disease or injury? _____

Name of operation _____

What test confirmed diagnosis? _____ Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify _____(Signed) Clark H. Benson M. D.(Address) 5111 York Rd.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07481
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

AUG 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/6/43 19 to 8/21/43 19.

and that I last saw him alive on 8/21/43 19.

Immediate cause of death

Carcinoma of Tongue
with metastases to neck

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/7/43

Major findings of operation:

Carcinoma of Tongue
of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07482

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07482

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2435 E. Monument St.

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) X

(e) Length of stay in Baltimore (yrs., mos., or days) 14 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2435 E. Monument St.
(If rural give location)(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME

Frank Richard Bundy

3 (b) If veteran, name war —

3 (c) Social Security Account
No. —

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 21, 1943

8. AGE: Years Months Days If less than one day
0 0 0 14 hr. 0 min.9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

12. Name Robert Wilson Bundy

13. Birthplace Port Deposit Md.

14. Maiden Name Dorothy Mae Wagner

15. Birthplace Clarendon Co S. Carolina

16 (a) Informant Dorothy Bundy

(b) Address 2435 E. Monument St.

17 (a) ~~Burial~~ Cremation (b) Date thereof 8/22/43
(month) (day) (year)(c) Cemetery or crematory Trinity Park
Location Frederick Mt. Cemetery
Morgan

18 (a) Funeral director

(b) Address 300 E. Baltimore

19 (a) AUG 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1943 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 19 to 8/22 1943
and that I last saw him alive on 8/21 1943

Immediate cause of death

Myocardial failure

Due to

Prematurity 28 weeks

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operations: 0

of autopsy: —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James K. Dinsley Jr.

Address 2436 E. Baltimore Date signed 8/22/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07483

MARYLAND STATE DEPARTMENT OF HEALTH

3411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

G 07483

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1302 St. Marks Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1302 St. Marks Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

No

3. (a) FULL NAME

Edward Joe Chester

3. (b) Social Security Number

Sex

M

Color or race

W

3. (a) Single, married, widowed, or divorced

Single

3. (b) Name of husband or wife

4. Birth date of deceased (mo., day, yr.)

Feb 16, 1922

5. (c) If alive, give age

1925

5. AGE:

Years

Months

Days

If less than one day

18

6

5

hrs.

min.

6. Birthplace

Baltimore City

(Town, county, and state)

7. Usual occupation

None

8. Industry or business

None

9. Name

John Martin Chester

10. Birthplace

Lithuania - Europe

11. Maiden name

Victoria Magdon

12. Birthplace

Lithuania, Europe

13. Informant

Father

Address

1302 St. Marks Ave.

14. Burial

(Burial, cremation, or removal. Which?)

Date buried

Aug 21 '43

15. Cemetery or crematory

Holy Redeemer Cem.

16. Location

Blair Rd.

17. Funeral director

Joseph Kasinskas Inc.

Address

621 Washington Blvd.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1943 at 2:51 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 21 at 2:20 PM '43 until Aug 21 - 6:14 PM '43

and that I last saw him alive on Aug 21

Immediate cause of death

Cardiac Failure

DURATION

12 yrs

Due to

Rheumatic Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (Where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. Caldwell M.D.

M. D. or other

Address

11 E. Chase St.

Date signed Aug 21, 1943

AUG 23 1943

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07484
439709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07484
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Gladys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-31-16

8. AGE:

Years

Months

Days

If less than one day

27

2

19

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

laborer

11. Industry or business

12. Name

William Brown

13. Birthplace

N.C.

14. Maiden Name

Mary Henson

15. Birthplace

N.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof

8 24 43

(burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Arbutus Men Park

Location

Arbutus, Md.

18 (a) Funeral director

William A. Jackson

(b) Address

916 Perryman Ave

19 (a) Signature

John H. Brown

20 (a) Address

Johns Hopkins Hospital

21 (a) Date signed

Aug 23 1943

22 (a) Signature

John H. Brown

23 (a) Address

Johns Hopkins Hospital

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

614 George St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1943 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1943 to Aug. 20 1943

and that I last saw him alive on Aug. 20 1943

Immediate cause of death

Tuberculosis Meningitis

Duration

3 weeks

Due to

Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Abraham Genevieve

Address

Johns Hopkins Hospital

Date signed

M. D.

8-23

G 07485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07485

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 662 Sarah Ann St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 662 Sarah Ann St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MabelSnowden

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored6 (a) Single, married, widowed, or
divorced Separated

6 (b) Name of husband or wife

Artie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-18908. AGE: Years 53 Months 3 Days 3
If less than one day
hr. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

House Work

11. Industry or business

12. Name Frank Washington13. Birthplace Md.14. Maiden Name Jennie S.15. Birthplace Md.16 (a) Informant Grace Carter(b) Address 662 Sara Ann St.17 (a) Burial (b) Date thereof 8-24-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematorium Arbutus Memorial Park
Location Arbutus Md.18 (a) Funeral director William C. Jackson(b) Address 916 Persimmon Ave19 AUG 23 1943 William C. Jackson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1943 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Acutemyocarditispulmonary edema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.Date signed August 21 1943 Medical Examiner

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07486
AB-81731

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07486
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md, (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Green St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Sarah Anderson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
F

5. Color or race
C

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18-1865

8. AGE: Years 78 Months 2 Days 27
If less than one day hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name Robert Smith

13. Birthplace Maryland

14. Maiden Name Anna Caster

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (b) Date thereof 23-48
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 23 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 1948 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1948 to 7/17 1948 and that I last saw her alive on 7/17 1948.

Immediate cause of death

Cardiac failure
Due to Hypertensive C.V.
disease

Due to

Other Conditions

Gen. arterio-
sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

E. J. Seigman
Address B C H

Date signed 8/16

Duration

?

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07487

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2021 W Lexington St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2021 W Lexington St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

Male White Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1860

8. AGE: Years Months Days If less than one day
82 10 13 hr. min.9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name George Shuman

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Anthony Shuman

(b) Address 2021 W Lexington St

17 (a) Burial (b) Date thereof 8-24-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or cremation location
New Catholic Balto. Md.

18 (a) Funeral director Harry H. Hinkle

(b) Address 4101 E. Lemon Ave.

19 (a) (b) Registrar

AUG 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1943 at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 4/20 1943 to 4/21 1943
and that I last saw him alive on 4/21 1943Immediate cause of death
Cerebral hemorrhage (spontaneous) 2 daysDue to Hypertensive and arterioscl-
erotic cardiovascular disease 5 yrs (1)Due to
Other Conditions Senility 5 yrs (1)(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
PHYSICIAN
Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 4/19/43 at 2:00 P.M.

(c) Where did injury occur? Baltimore, Maryland
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? Home While at work? No
(Specify type of place)(e) Means of injury attack of vertigo
Fell down cellar steps during

23. Signature Thos E. Conner

Address 3629 Edmondson Ave. Date signed 4/22/43
M.D.

Approved by Howard J. Mallico, M.D.

G 07488

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07488
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3421 E. Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3421 E. Pratt St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frederick J. Schultz

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-01-2770

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Catherine neJakob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1903

8. AGE:

Years

Months

Days

less than one day

40415

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Asst Foreman

11. Industry or business

Hanger Shirt Co.

MOTHER / FATHER

12. Name

Schultz

13. Birthplace

Maryland

14. Maiden Name

Anna Wagner

15. Birthplace

Maryland

16 (a) Informant

Mrs. Catherine Schultz

(b) Address

3421 E. Pratt St

17 (a)

Burial

(b) Date thereof

Aug 26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto Md

18 (a) Funeral director

Wm H. Heston

(b) Address

4101 E. Diamond St

19 (a)

8/23/43

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/22 1943 4:15 AM21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to death death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Lugh B. Michalsky M.D.

Medical Examiner.

Date signed

8/23/43

G 07489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07489

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3820 Penhurst Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore City.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3820 Penhurst Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Margaret B. Dunning

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife William J. Dunning

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 19, 1896

8. AGE:

Years

Months

Days

If less than one day

47

3

3

hr.

min.

9. Birthplace Phila., Pa.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At home

FATHER

12. Name Walter T. Wooters

13. Birthplace Delaware.

MOTHER

14. Maiden Name Lillian Pullerton.

15. Birthplace Lancaster Co., Penna.

16 (a) Informant Mr. William J. Dunning.

(b) Address 3820 Penhurst Ave.

17 (a) Burial (b) Date thereof 8/26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Fernwood Cemetery

Location Philadelphia, Penna.

18 (a) Funeral director B. Vernon Lemon

(b) Address 4611 Park Heights Ave.

19 AUG 23 1943 (b) Huntington Williams, M.D.

(Date rec'd, register)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1943 19 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8/22/19 43.

and that I last saw him or alive on 8/22/19 43.

Immediate cause of death

Circulatory

failure

Duration

7 days

Due to Intestinal Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Arthur W. Kas

M. D.

Address 3862 Dolfield Blvd

Date signed

G 07490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 G 07490

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2112 W. Lexington Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2112 W. Lexington St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret A. Streett

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Charles W. Streett

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 24th, 1890

8. AGE: Years Months Days If less than one day
53 6 27 min.9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own home

12. Name James Stran

13. Birthplace Baltimore Md.

14. Maiden Name Sabina Prince

15. Birthplace Maryland

16 (a) Informant Charles W. Streett

(b) Address 2112 W. Lexington Street

17 (a) Burial (b) Date thereof Aug. 24, 1943

(Burial, cremation, or reburial) (month) (day) (year)

(c) Cemetery or crematorium

Location

18 (a) Funeral director George J. Roth, Inc.

(b) Address 1735 Harford Avenue

(Date rec'd by registrar)

6-23-43

V8 136

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1943, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1943, to Aug. 21, 1943, and that I last saw her alive on Aug. 20, 1943.

Immediate cause of death

Adenocarcinoma of
Left Breast

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 400 N. Payson St. Date signed 8/24/43

Duration

3 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07491

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: *Hospice 2**Bethlehem - Fairless Suburban Corp.*(d) Length of stay in hospital or inst. (yrs., mos., or days) *3*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *402 S. Caroline St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME *James Bish*

3 (b) If veteran, name war

3 (c) Social Security Account

No. *218-05-9020*

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Sarah Bish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 24, 1902

8. AGE:

Years

Months

Days

If less than one day

*40**10**26*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Chaffer

11. Industry or business

Bethlehem - Fairless S-B. Corp.

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Mary

15. Birthplace

Hampton, Va.

16 (a) Informant

Sarah Bish(b) Address *402 S. Caroline St*17 (a) *Burial*

(b) Date thereof

Aug. 24, 1943

(c) Cemetery or crematory

Calverton National Cemetery

Location

Calverton National Cemetery

18 (a) Funeral director

Robert H. Green

(b) Address

804 W. Caroline St.

19 (a)

*AUG 23 1943**Washington, D.C.*

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-20-1943

at

M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Acute myocardial infarction

Due to

Other Conditions

*Chronic myocardial infarction**Coronary artery atherosclerosis*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Thomas J. Wallace

M.D.

Date signed

8/20/43

Medical Examiner.

G 07492

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07492

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green + Redwood.

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore(d) Street No. 1515 W. Pratt Street

(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

J. Kennard

3 (b) If veteran, name war

3 (c) Social Security Account

No. 117-03-3010

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Marguerite6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

July 10, 1905

8. AGE: Years Months Days

38 1 10 hr. min.9. Birthplace Queen Anne's County, Maryland10. Usual Occupation Stationary Engineer11. Industry or business Hochschild, Kohn Co.12. Name Thomas T. Swann13. Birthplace Queen Anne's County, Md.14. Maiden Name Bertha C. Gutter15. Birthplace Queen Anne's County, Md.16 (a) Informant Marguerite Swann(b) Address 1515 W. Pratt Street17 (a) Burial (b) Date thereof 8-24-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Univ. CathedralLocation Baltimore, Maryland18 (a) Funeral director George H. SchwalbFrederick AvenueHuntington Williams, M.D.

(Date rec'd by registrar)

Registrar

20. DATE OF DEATH August 20, 1943 at 4 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-1943 to 8-20-1943and that I last saw him alive on 8-20-1943.

Immediate cause of death

Primary TuberculosisDue to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature H. B. HagenAddress Univ. Hosp. Date signed 8/20/43

M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Duration

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

YB 150

G 07493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07493

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

19 (a) (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 23

1943, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1943, to 8/23 1943, and that I last saw h/m alive on 8/23 1943.

Immediate cause of death

Respiratory failure

Due to

Erythroblastosis fetalis?

Due to

Congenital atresia?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Penahan

M. D.

Address Unit - Hospital

Date signed 8/23

VS 154

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07494
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 321 N. Stricker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 321 N. Stricker St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Bertha H. Griffin

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced. MarriedFemale Colored6 (b) Name of husband or wife Walter Griffin6 (c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) Feb 22, 18968. AGE: Years 47 Months 6 Days 28
If less than one day
hr. min.9. Birthplace Westminster Md
(Town, county, and state)10. Usual Occupation Housewife

11. Industry or business

12. Name Henry Hardy13. Birthplace Md14. Maiden Name Emma15. Birthplace Md16 (a) Informant Lillian Smith (S)(b) Address 1020 Warner St17 (a) Burial (b) Date thereof 8-24-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt CalvaryLocation W & E Md18 (a) Funeral director Isaiah L. Brown(b) Address 108 W Montgomery St19 AUG 23 1943 Hunting for Williams, 432
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1943 at 4 30 PM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Statusepilepticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature Robert L. Gratan MDDate signed August 21 1943
Medical Examiner.

G 07495

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07495
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 123 W. Hamburg

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 79 43

3 (a) FULL NAME William Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Mary Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 79 Months - Days - If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Boat

12. Name Unknown

13. Birthplace

14. Maiden Name Sarah Jane Harris

15. Birthplace Baltimore

16 (a) Informant Eva J. Jernix

(b) Address 106 W Cross

17 (a) Burial (b) Date thereof 8-24-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location 49 W Mt

18 (a) Funeral director Isaiah L. Beardsley

(b) Address 108 W Montgomery St

19 (a) Date of death 1943

(b) By whom reported by Dr. H. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 123 W Hamburg (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/43 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/43 to 8/20/43

and that I last saw him alive on 8/20/43

Immediate cause of death Chronic

Myocardial

infarction

Due to Myocardial

infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dr. H. Williams

Address 123 W Cross

Date signed 8/20/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (d) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

63

5

1

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) AUG 24 1943

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 23rd 1943 2³⁵ M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1943 to Aug 23 1943.

and that I last saw him live on Aug 20 43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Signed 8/23

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07497

AUBEL

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07497

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Funeral

(b) Date thereof

(c) Cemetery or crematorium

18 (a) Funeral director

(b) Date

19 (a) (Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940, to Aug 22 1943 and that I last saw her alive on Aug 22 1943.

Immediate cause of death

Coronary artery

Duration

3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2818 24th Ave

Date signed

8/24/43

G 07498

BALTIMORE CITY HEALTH DEPARTMENT

G 07498

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5324 Wesley Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

William H. Owens

3 (b) If veteran, name war

3 (c) Social Security Account

No.

NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Florence Owens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

Feb 28 - 1871

8. AGE:

Years

Months

Days

If less than one day

72

65

024

hr.

min.

9. Birthplace

Balto Md.

(Town, county and state)

10. Usual Occupation

Paint Finisher

11. Industry or business

Morris Bros

FATHER

12. Name

(Unknown)

Owens

13. Birthplace

"

MOTHER

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant

Geo. Owens

(b) Address

5324 Wesley Ave

17 (a)

Burial

(b) Date thereof

8/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Dread Ridge

Location

Pikesville Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

19 (a)

8/24/1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

AUGUST 22, 1943, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended

deceased from 8-5 1942 to 8-22 1943.

and that I last saw him alive on 8-15 1943.

Immediate cause of death

Coronary Occlusion

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the followings

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Norman R. Kleiman

M.D.

Address 1101 N. Fulton Ave

Date signed 8/23/43

G 07499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07499

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 603 Scott St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Margaret Reed

3 (b) If veteran, name war

3 (c) Social Security Account

No 219-03-3246

4. Sex

FEM

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife Arthur Reed

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.)

1/28/02

8. AGE:

41

Months

6

Days

25

If less than one day

hr.

min.

9. Birthplace

Mass.

(Town, county, and state)

10. Usual Occupation

Inspector

11. Industry or business Bendix

FATHER

12. Name Mr. Nichols Joseph Wallace

13. Birthplace Boston Mass.

MOTHER

14. Maiden Name Mrs Bridget Wallace

15. Birthplace Ireland

16 (a) Informant Mr Nichols Jos. Wallace Jr

(b) Address 603 Scott St.

17 (a) BURIAL (b) Date thereof AUG 26 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral Cem

Location

18 (a) Funeral director Bernard C Harter

(b) Address 121 E West St

19 (a) AUG 24 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1943 at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8:16 1943 to 8:23 1943

and that I last saw her alive on 8:23 1943

Immediate cause of death

Peripheral Vascular collapse

Due to

Paralytic Illness (Post-operative)

Due to

Pelvic Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/17/43

Major findings of operation: Fibroid uterus

cystic ovary, Chronic Cervicitis, Adhesions

of autopsy: Same

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward L F Krieg

Address Bon Secours Hosp Date signed 8/27/43

G 07500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07500

Registered No. G 07500

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1340 - W. Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1340 - W - Lafayette Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days
6 1943
If less than one day
hr. min.9. Birthplace Asbury Park, N.J.
(town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John H. McLean13. Birthplace N. C.14. Maiden Name Helen Rodgers15. Birthplace Balto. Co. Md.16 (a) Informant Helen McLean(b) Address 1340 - W. Lafayette Ave17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)(c) Cemetery or crematory mt. Auburn
Location West part md.18 (a) Funeral director Geo H. O'Leary(b) Address 927 - N. Mount St19 (a) (b)
(Date rec'd by registrar)

AUG 24 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1943 20 M21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1943 to 8/23 1943 and that I last saw him alive on 8/23 1943

Immediate cause of death

Illo - Cholera

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

B. J. Hatcher
Address 1225 La Arca Date signed 8/23/43

Duration

24

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07501

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1016 E. Chase St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1016 E. Chase Street

(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Baby Boy Nicholson

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1943

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12 Name Edward Wayne Nicholson

13. Birthplace Connellsville Penna

14. Maiden Name Genevieve M. Stewart

15. Birthplace Blaine, West Virginia

16 (a) Informant Edward Wayne Nicholson

(b) Address 1016 E. Chase Street

17 (a) Burial (b) Date thereof 8-24-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Ave. Baltimore Md

18 (a) Funeral director Albert L. Hill

(b) Address 1806 N. Chester Street

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1943 at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20/43 19 to 8/22 1943 and that I last saw him alive on 8/22 1943.

Immediate cause of death

Ducts

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

707 E. Chase

Date signed

M. D.

8/24/43

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 07502

CAUDILL
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a ✓ G 07502
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2703 White Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2703 White Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Virginia B. Caudill

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow6 (b) Name of husband or wife Edward F. Caudill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27, 18728. AGE: Years 70 Months 8 Days 25
If less than one day hr. min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

12. Name

John Rhodes

13. Birthplace

Va

14. Maiden Name

Catherine Henderson

15. Birthplace

Va16 (a) Informant Theodore R. Kittredge(b) Address 2703 White Ave17 (a) Burial (b) Date thereof Aug 25, 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Landon ParkLocation Balta18 (a) Funeral director Leonard J. Ruck(b) Address 5305 Theford Rd.

19 (a) (b)

(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1943 at M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1943 to Aug 22 1943 and that I last saw him alive on Aug 20 1943

Immediate cause of death

Arteriosclerotic cardiac-musclerenal diseaseDue to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type and place)

(e) Means of injury

23. Signature William H. D.Address 6217 Hafford Rd Date signed 8/23/43

Duration

2 yrs3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07503
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 24 1943

(c) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town list, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1943 to Aug 21 1943, and that I last saw him alive on Aug 21 1943.

Immediate cause of death

General Carcinoma

Due to Carcinoma Lung (Rt)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07504
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1723 Homestead St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 32 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State Md, (b) County - - -

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1723 Homestead St.
(If rural give location)(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY ANNA MEYERS

3 (b) If veteran, name war
no3 (c) Social Security Account
No. none4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or
divorced married

6 (b) Name of husband or wife William F. Meyers

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Jul. 27, 1883

8. AGE: Years Months Days If less than one day
57 0 24 hr. min.9. Birthplace Lonaconing Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Michael Welsh

13. Birthplace Maryland

14. Maiden Name Katherine Gill

15. Birthplace England

16 (a) Informant Mr. Wm. F. Meyers (Husband)

(b) Address 1723 Homestead St.

17 (a) Burial (b) Date thereof Aug. 25, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address North Howard St. Baltimore, Md.

AUG 24 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1943 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from August 1941 to Aug 21, 1943
and that I last saw him alive on Aug 21, 1943

Immediate cause of death

Cama
Diabetes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Fritz J. Kunzler M.D.

Address 2700 Harford Road Date signed Aug 23, 1943

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07505
137N Registered No. 07505

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Frederick

(c) City or town

Thurmont (If outside city or town limits, write RURAL and give town)

(d) Street No.

Rt. 1 N Lewistown

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Clarence D. Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-70

8. AGE: Years Months Days If less than one day

73 6 3 hr. min.

9. Birthplace

Utica Mills Md

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Farmer

12. Name

David Lambert

13. Birthplace

Md

14. Maiden Name

Frances Doms

15. Birthplace

Walkersville, Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

8/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Utica

Location

Utica Mills

18 (a) Funeral director

M. J. Creager & Son

(b) Address

Thurmont, Md

AUG 24 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1943 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1943 to Aug. 22 1943 and that I last saw him alive on Aug. 22 1943.

Immediate cause of death

Cardiac

failure

Due to

uremia

Due to

Other Conditions

Remar

(Include pregnancy within 3 months of death)

Date of operation

July 14, 1943

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edw. J. Richardson, Jr.

Address

Johns Hopkins Hosp

Date signed

8/23/43

Duration

About

1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07506

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *John & Lafayette Sts.*

(c) Hospital or institution:

Hospital for Women of Maryland(d) Length of stay in hospital or inst. (yrs., mos., or days) *3*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3306 Clifton Ave*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Bertha Preetzel Joeckel

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced6 (b) Name of husband or wife *John H. Joeckel*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *11/19/1880*

8. AGE:

Years

Months

Days

If less than one day

*62**9**4*

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

FATHER
MOTHER12. Name *George Preetzel*13. Birthplace *Germany*14. Maiden Name *Anna Smith*15. Birthplace *Germany*16 (a) Informant *Mr. John H. Joeckel*(b) Address *3306 Clifton Ave.*17 (a) *Burial* (b) Date thereof *8/26/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Loudon Park Cem.**Balto., Md.*18 (a) Funeral director *WM. J. TICKNER & SONS*(b) Address *Balto., Md.*19 (a) *AUG 24 1943*
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 23 1943* at *2:28 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 20 1943* to *Aug 23 1943*, and that I last saw her alive on *Aug 23 1943*.Immediate cause of death *Cardio-respiratory failure with pulmonary edema*Due to *intestinal obstruction, mechanical*Due to *intestinal collections*Other Conditions *Myocarditis*

(Include pregnancy within 3 months of death)

Date of operation *Aug. 22 1943*Major findings of operations *intestinal obstruction due to adhesions*of autopsy: *none*

Duration

*12 hrs**4 days**?*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *William C. Gilman M.D.*

M. D.

Huntington Hillman, Hospital for Women of Md., Balto., Md. Date signed *Aug 24 1943*

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07507
119A Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Madison + Howard*
(c) Hospital or institution: *Md. Gen. Hosp*
(d) Length of stay in hospital or inst. (*yes, mos., or days*) *13*
(e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1332 W. North Av.*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

B. Ionia Jean Barghorn

3 (b) If veteran, name was

--

3 (c) Social Security Account

No. --

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

--

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? *May 13, 1943*

8. AGE: Years Months Days If less than one day
3 *9* hr. min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *William Barghorn*

13. Birthplace *Baltimore*

14. Maiden Name *Mary Harrison*

15. Birthplace *Baltimore*

16 (a) Informant *Mr. Wm. H. Barghorn*

(b) Address *1339 W. North Ave.*

17 (a) *Burial* (b) Date thereof *8/25/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Olivet Cem.*
Location *Balto., Md.*

18 (a) Funeral director *WM. J. TICKNER & SONS*

(b) Address *Balto., Md.*

19 *AUG 24 1943* (b) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 22 1943* at *10* P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from *August 24 1943* to *August 22 1943* and that I last saw her alive on *Aug. 23 1943*.

Immediate cause of death

Acidosis and dehydration

Due to

Dianhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Herman Williams* M. D.

Address *Md. Gen. Hosp* Date signed

August 22, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information entered on this certificate is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07508

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

11 days

3 (a) FULL NAME

Wylie Howell Smith, Jr.

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 11, 1943

8. AGE: Years

Months

Days

If less than one day

11

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Wylie Howell Smith

13. Birthplace

Georgia

MOTHER

14. Maiden Name

Aline Atkins

15. Birthplace

Georgia

16 (a) Informant

Father, Wylie H. Smith, Sr.

(b) Address

Same 3100 Parkside Drive

17 (a) Burial

(b) Date thereof 8/24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

AUG 24 1943

(Huntington Mill)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3100 Parkside Drive

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 22, 1943 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20, 1943 to Aug. 22, 1943, and that I last saw him alive on Aug. 22, 1943.

Immediate cause of death

Dissection of neurons

Duration

4 days

Due to

Due to

Other Conditions

Tubercular broncho pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. Mary L. Haydel

Address

229 E. 3rd St.

Date signed 8/23/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07509

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 ~~82~~ at 5:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1983 to 8/23 1983,

and that I last saw h/ alive on 8/23 1983.

Immediate cause of death Myocardial failure

Duration

Due to Myocardial infarction

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Address Sinai Hospital

Date signed 8/23/83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 24 1983

VS 180

Registrar

G 07510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07510
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 CHAUNCEY AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County:(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 901 CHAUNCEY AVE
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

MICHAEL MEYERS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

ESTHER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/19/1882

8. AGE:

Years

Months

Days

If less than one day

601117

hr.

min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

MERCHANT -SELF

11. Industry or business

FATHER
MOTHER

12. Name

LOUIS MEYERS

13. Birthplace

RUSSIA

14. Maiden Name

ROSE

15. Birthplace

RUSSIA16 (a) Informant ESTHER MEYERS

(b) Address

901 CHAUNCEY AVE17 (a) BURIAL
(Burial, cremation, or removal)(b) Date thereof 8-24-43
(month) (day) (year)

(c) Cemetery or crematory

BALTO. Hebrew

Location

Belair Rd18 (a) Funeral director JACK LEWIS INC

(b) Address

2100 EUTAW PLACE19 AUG 24 1943
by registrar(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22 1943 1:30 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 15 1943 to AUG. 22 1943, and that I last saw him alive on Aug. 21 1943.

Immediate cause of death:

Myocardial Failure

Duration

2 hrs.

Due to

Coronary Occlusion2 hrs.

Due to

Coronary Artery Disease4 yrs.

Other Conditions

ease4 yrs.

Other Conditions

Arteriosclerosis4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Herbert Goldstone

Address

2443 Linden Ave

Date signed

Aug 22 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07511

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 228 S. Chester Street
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MICHAEL A. PIECHOWIAK

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) 8/4/16

8. AGE: Years Months Days If less than one day

2717

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Michael Piechowiak13. Birthplace Poznan, Poland14. Maiden Name Martha Paska15. Birthplace Baltimore, Maryland16 (a) Informant Mr. Michael Piechowiak(b) Address 228 S. Chester Street17 (a) Burial (b) Date thereof 8/25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. StanislausLocation Mt. Carmel Road18 (a) Funeral director M. J. Sadowski & Sons(b) Address 1808 Gorkin Ave.AUG 24 1943 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 21 1943 at 8:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 14 1943 to AUG. 21 1943, and that I last saw him alive on AUG. 21 1943.

Immediate cause of death

LOBAR PNEUMONIA

Duration

3 DAYS

Due to

Due to

SPASTIC HEMIPLEGIA (RIGHT)1923Other Conditions (FOR DIAGNOSIS & RECORD)
SEE JOHN'S HOPKINS HOSPITAL

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Joseph F. Sadowski
209 S. Chester St.Signed 8/23/43

Correct age is especially important. To determine, please write the causes of death clearly and legibly.

G 07512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07512
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 2010 Hollins St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2010 Hollins St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME

Cora V. Tucker (Cora V. Tucker.)

(b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Widow

(b) Name of husband or wife. William Tucker.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1883

8. AGE: Years Months Days If less than one day
60 2 2 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

12. Name Philip Newton

13. Birthplace Baltimore

14. Maiden Name Core Sagle

15. Birthplace Baltimore

16 (a) Informant Marie Bull (Marie Bull.)

(b) Address 2010 Hollins Street

17 (a) Burial (b) Date thereof 8. 26. 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Robert L. Brooks.

(b) Address 1338 Hollins Street

19 (a) AUG 24 1943
(Date of registration) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1943, at 7 PM

21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Dysentery

Due to

(Signature)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

August 23, 1943
Medical Examiner.

G 07513

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2228 Prentiss Place

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2228 Prentiss Place

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

MARIE LOUISE PROCHASKA (nee Tuma)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/25/65

8. AGE: Years Months Days If less than one day

78 years

3

25

hr.

min.

9. Birthplace Czechoslovakia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name

Unknown

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant Julia Ogrinz (daughter)

(b) Address 2210 Prentiss Place

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 3/24/43

(month) (day) (year)

(c) Cemetery or crematory

Oak Hill

Location Phila. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schirasek

(b) Address 2601 E. Madison Street

AUG 24 1943

VB 146

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1943, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1943, to Aug 20 1943, and that I last saw her live on Aug 20 1943.

Immediate cause of death

Coronary Thrombosis

Duration

18 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Joseph Pokorny M.D.
2200 E. Madison St. Date signed 8/20/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 120

G 07514

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

(a) FULL NAME

(b) If veteran, name war

3 (c) Social Security Account No.

Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

(b) Name of husband or wife

6 (c) If alive, give age

Birth date of deceased (mo., day, yr.)

AGE:

Years

Months

Days

If less than one day

Birthplace

2. Usual Occupation

3. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

6 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date of

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19

(Note rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 21 1943 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1943, to Aug 21 1943, and that I last saw him alive on Aug 21 1943.

Immediate cause of death

Acute nephritis

Duration

3 wks

Due to

Due to

Other Conditions

uremia

1 wk

PHYSICIAN

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Calvin B. He Compt

Address 1113 N. Caroline St

Date signed 8/23/43

G 07515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07515

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1146 Spendall Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1146 Spendall Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gallup

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11, 1943

8. AGE:

Years

Months

Days

If less than one day

12

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

James Edward Gallup

13. Birthplace

Baltimore, Md.

14. Maiden Name

Ethel Hammer

15. Birthplace

Baltimore, Md.

16 (a) Informant

James E. Gallup

(b) Address

1146 Spendall Ave.

17 (a) Burial

(b) Date thereof Aug 14, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Baltimore Cem.

Location

North Ave. & 1st St.

18 (a) Funeral director

Nesbitt, Whipple

(b) Address

808 S. Highland Ave.

19 (a) Rec'd by registrar

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1943, at 7 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 1943, to Aug. 23, 1943, and that I last saw him alive on Aug. 21, 1943.

Immediate cause of death

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. A. Rosenblatt

Address 308 O'Donnell St. Date signed 8/23/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important

Huntington Williams, M.D.

G 07516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07516

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1021 Russell St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1021 Russell St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 18898. AGE: Years 53 Months 11 Days 24 hr. 27 min.9. Birthplace St. Louis, Mo.
(Town, county, and state)10. Usual Occupation Housewife

11. Industry or business

12. Name William Myas13. Birthplace England14. Maiden Name Unknown

15. Birthplace

16 (a) Informant George Gore(b) Address 1021 Russell St.17 (a) Burial (b) Date thereof 8/27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.18 (a) Funeral director Edward H. Blight, Jr.(b) Address 4914 Belair Road19 (a) AUG 31 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1943 12:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1943 to 8/24 1943, and that I last saw him alive on 8/24 1943.

Immediate cause of death

Cerebral Hemorrhage
Due to Hypertension Cardio
Due to vascular Renal Disease

Duration

8/21/43
5 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph H. LawranceAddress 679 Washington St. Date signed 8/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07517

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 22nd1943, at 6th M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21st 1943, to Aug 23 1943, and that I last saw him alive on Aug 23 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 07518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07518

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert

(c) Hospital or institution:

W. M. H.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 400 Lyman Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

No

(Yes or No)

3 (a) FULL NAME

Mrs. Leonore G. Doyle (LEONORE Griffith Doyle)

3 (b) If veteran, name was

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife James C. Doyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1854

8. AGE: Years Months Days If less than one day

88

10

14

hr.

min.

9. Birthplace Maryland - BALTIMORE

(Town, county, and state)

10. Usual Occupation

11. Industry or business

NONE

12. Name Mr. Cornelius R. Griffith

13. Birthplace Maryland

14. Maiden Name Alberta Griffith

15. Birthplace Maryland

16 (a) Informant Mr. Arthur R. Doyle (Son)

(b) Address 400 Lyman Ave. City # 12

17 (a) Entombment (b) Date thereof Aug 25, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Green Mount at Oliver

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (R. F. WOODEN SOC.) 100 W. NORTH AVENUE

19 (a) AUG 24 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1943, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15, 1943, to Aug 23, 1943, and that I last saw her alive on Aug 23, 1943.

Immediate cause of death Cardiac respiratory failure

Due to Cerebral Accident

Due to (Spontaneous)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: none

of autopsy: none

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Griffith

Address Union Memorial Hospital Date signed 8-23-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07519

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 540 S. Addison St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Jusie Stokely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Joseph Stokely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1851

8. AGE:

Years

Months

Days

If less than one day

92

hr.

min.

9. Birthplace

Eastern Shore, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Jolson

13. Birthplace

Md.

MOTHER

14. Maiden Name

Anna Jolson

15. Birthplace

Md.

16 (a) Informant

Jessie Smith

(b) Address

1804 Eagle St.

17 (a) Burial

(b) Date thereof

Aug 24-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem

Location

18 (a) Funeral director

Mrs. V. R. Williams

(b) Address

522 N. Holliday St.

19 AUG 24 1943

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/21

10/3

10 PM

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to a natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive Cardiac-vascular
renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh R. McKelvey M.D.

Date signed 8/23/43 Medical Examiner.

G 07520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07520
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. Provident Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 918 W. Franklin St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Samuel White

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4: Sex

M

5. Color or race

C6 (a) Single, married, widowed, or
divorced.Widowed6 (b) Name of husband or wife Elizabeth White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 2, 1884

8. AGE: Years Months Days If less than one day

59320

hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)10. Usual Occupation Laborer

11. Industry or business

12. Name Jesse White13. Birthplace Calvert Co., Md.14. Maiden Name Rebecca Ringold15. Birthplace Balto., Md.16 (a) Informant Ida Walker(b) Address 419 Pearl St.17 (a) Buried (b) Date thereof Aug. 25-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Wm. Katis R. Williams(b) Address 322 N. Schombers St19 (a) Huntington Williams, M.D.
Registrar

AUG 24 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1943 3:30 A.M.21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature Hugh B. McEllynoDate signed 8/23/43 Medical Examiner.

G 07521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07521

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 833 W. Fairmount Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Raymond

Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Viola Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 18, 1909

8. AGE:

Years

Months

Days

If less than one day

33

4

3

hr.

min.

9. Birthplace

West Point, Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

William Cooper

13. Birthplace

Va.

14. Maiden Name

Ada Turrel

15. Birthplace

Va.

16 (a) Informant

Anne Young

(b) Address

833 W. Fairmount Ave

17 (a) Burial

(b) Date thereof

Aug. 25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cem.

Location

18 (a) Funeral director

Mrs. Katie R. Williams

(b) Address

322 N. Schroeder St.

19 (a)

Aug 24 1943

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1943, at 11 PM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture-dislocation

of 6th cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury August 14 1943 M.

(b) Where did injury occur? Washington Blvd 1 mile

(c) Did injury occur at home, on farm, industrial place, in public

place? highway While at work? no

(d) Means of injury Auto accident

23. Signature Robert E. Graham M.D.

Date signed August 23 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07522
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2903 Poplar Terrace
(c) Hospital or institution: Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 W. Penna. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George L. Winand Jr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 168-14-2866

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6 4 1923

8. AGE:

Years

Months

Days

If less than one day

20

2

19

hr.

min.

9. Birthplace

YORK, PA.

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

FATHER
MOTHER

12. Name GEO. L. WINAND SR.

13. Birthplace YORK, PA.

14. Maiden Name HELEN LEGG

15. Birthplace YORK PA.

16 (a) Informant G. W. HAYERSTOCK

(b) Address YORK PA.

17 (a) BURIAL (b) Date thereof 8/26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory GREENMOUNT

Location YORK PA.

18 (a) Funeral director Wm. J. Johnson

(b) Address High St. Penna. Ave

19 (a) 8/24/43 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/43 8 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

Signature Hugh B. McWhally M.D.

Date signed 8/24/43 Medical Examiner.

G 07523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07523
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland **pinewood Ave**
 (b) Street address **2915**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**
(If outside city limits, write RURAL and give town)(d) Street No. **2915 Pinewood Ave**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary A Skrivan

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Female5. Color or race
white6 (a) Single, married, widowed, or
divorced. **married**6 (b) Name of husband or wife **Frank F. Skrivan**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Aug 3 1878**8. AGE: Years Months Days If less than one day
65 - 20 14 hr. min.9. Birthplace **Baltimore**
(Town, county, and state)10. Usual Occupation **Housewife**

11. Industry or business

12. Name **John Hoffmann**13. Birthplace **Md**14. Maiden Name **Don't Know**

15. Birthplace

16 (a) Informant **Frank F. Skrivan**
(b) Address **2915 Pinewood Ave**17 (a) **Burial** (b) Date thereof **Aug 26 / 43**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Cemetery or crematory **Holy Redeemer**
Location **Belair Road**18 (a) Funeral director **Ullrich Funeral Home**
(b) Address **2008 Orleans St**

(b) Address

19 (a) **8/24/43** (b)
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 22 1943 at 11⁵⁰ P M**21. I certify that death occurred on the date above stated; that I attend-
ed deceased from **1941** to **Aug 22 1943**and that I last saw him alive on **Aug 22 1943**

Immediate cause of death

**Pulmonary edema
Acute myocardial infarction
Due to renal disease**

Duration

**1 hr
2 yrs**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

6217 Hayford RdDate signed **8/24/43**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07524
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert St.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 712 E. 21st St.
(If rural give location)(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME

George Augusta Kohrs

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or
divorced. widower

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/19/91

8. AGE:

Years

Months

Days

If less than one day

67

11

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation Md. Pa. R.R.

11. Industry or business pensioner

12. Name Henry A. Kohrs

13. Birthplace Germany

14. Maiden Name Lena Bonhage

15. Birthplace Germany

16 (a) Informant daughter, Mrs. Freeman

(b) Address 712 E. 21st St.

17 (a) Burial (b) Date thereof Aug 26

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 - 8. Orleans St.

19 (a) 8/24/43 (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1943, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 19, 1943, to Aug 23, 1943,
and that I last saw him alive on Aug 23, 1943.

Immediate cause of death

Cardio-Respiratory Failure
Pneumonia left L. Lobe

Due to

Due to

Other Conditions Chronic Asthma

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Nesbitt Jr.

Address Union Memorial Hospital Date signed 8-23-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07525

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 232 S Clinton

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2 (a) FULL NAME

William H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Amelia Smith

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 11 1872

8. AGE:

Years

Months

Days

If less than one day

71

4

12

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Baltimore City

11. Industry or business

Incinerator

FATHER

12. Name

Louis H. Smith

13. Birthplace

MOTHER

14. Maiden Name

Mary E. Harton

15. Birthplace

Baltimore

16 (a) Informant

Amelia Smith

(b) Address

232 S Clinton

17 (a) Burial

(b) Date thereof

Aug 26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Morial and Memorial

Location

Rural

18 (a) Funeral director

Lelrick Funeral Home

(b) Address

2004-8 S. Orleans St

19 (a) 8/24/43

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) Street

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

232 S Clinton

(If rural give location)

(a) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 23

1943

at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 42 to Aug 23 19 43 and that I last saw him alive on Aug 23 19 43

Immediate cause of death

Cardio-vascular renal
Due to disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

George J. Miller, M.D.

Address

2739 Eastern Ave

Date signed 8/24/43

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07526

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2803 Harrison Blvd.

(c) Hospital or institution:

Prout Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife late Mr. Sydney

O. Heiskell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1869

8. AGE: Years 73 Months 11 Days 24 hr. min.

9. Birthplace New York

10. Usual Occupation Physician

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Albert C. Kunkel

(b) Address 605 Coleraine Rd.

17 (a) Removal (b) Date thereof Aug 24/43

(c) Cemetery or crematory

Greenhays Creek, Pa.

18 (a) Funeral director Harry V. Stitzke

(b) Address 4101 E. Lombard Ave.

19 (a) 8/24/43 (b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give locality)

(d) Street No. 605 Coleraine Rd.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1943 to Aug 22 1943 and that I last saw her alive on Aug 21 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

4 Mo.

Due to Arterial Hemorrhage

6 yrs.

Due to

Other Conditions Fracture Hip

4 Mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

S. Lloyd Johnson

M. D.

Address

Catonville

Date signed

8/23/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07527

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2561 McCulloh St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2561 McCulloh St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Harrison Peaco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored6 (a) Single, married, widowed, or divorced. **Married**6 (b) Name of husband or wife **Rosia Peaco**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept 11, 1887**8. AGE: Years **55** Months **11** Days **11** If less than one day hr. min.9. Birthplace **Harford Co., Md.**

(Town, county, and state)

10. Usual Occupation **Laborer**

11. Industry or business

12. Name **James F. Peaco**13. Birthplace **Md.**14. Maiden Name **Rachel A. Moore**15. Birthplace **Md.**16 (a) Informant **Mrs Rosia Peaco**(b) Address **2561 McCulloh St.**17 (a) **Burial** (b) Date thereof **8-25-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Mt. Calvary Cem.**Location **A. A. Co., Md.**18 (a) Funeral director **Mrs Frances A. Hemaley**(b) Address **578 W. Biddle St.****AUG 24 1943**

Registrar

Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH **AUG. 22, 1943, at 3:30M**21. I certify that death occurred on the date above stated; that I attended deceased from **7/20/43** to **8/22/43** and that I last saw him alive on **8/22/43**

Immediate cause of death

**Central apoplexy
+
Paralysis**

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **B. R. Smith** M. D.Address **2739 W. Biddle St.** Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07528
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

AUG 24 1943

Huntington Williams

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw h

alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

M. D.

AUG 23

1943

G 07529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07529

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd. + Calvert Sts.

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 93 days(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1921 Longwood St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mrs. George Denderson Smith Sr. (Ora Adelle Smith)

3 (b) If veteran, name war

3 (c) Social Security Account
No. --

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W6 (b) Name of husband or wife Mr. George D. Smith Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1868

8. AGE: Years Months Days If less than one day

75020

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

Housewife

FATHER

12. Name Mr. Willie Neister13. Birthplace Virginia

MOTHER

14. Maiden Name Matthie Hughes15. Birthplace Virginia16 (a) Informant Mr. George F. Smith(b) Address 3704 Winterbourne Rd.17 (a) Burial (b) Date thereof 8/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.Location Woodlawn, Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19. ADG 24 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1943. 6:50 AM21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1943. to August 24 1943. and that I last saw him alive on August 23 1943.Immediate cause of death Cardiac-respiratory failure

Duration

7 monthsDue to Chronic Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George W. Montgomery Jr. M. D.
Address 332 S. Community Chm. Date signed 9/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECTING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH OYFDRING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07530

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore Gen'l. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4105 Springdale Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

ROBERT UNKEFER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Bertha R. Unkefer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14/1881

8. AGE: Years Months Days

62

0

10

If less than one day

hr.

min.

9. Birthplace Libertytown, Md.

(Town, county, and state)

10. Usual Occupation Mail Order Business

11. Industry or business Self

12. Name John Unkefer

13. Birthplace unknown

14. Maiden Name Fannie Gorsuch

15. Birthplace unknown

16 (a) Informant Mrs. Bertha R. unkefer

(b) Address 4105 Springdale Ave.

17 (a) Burial (b) Date thereof 8/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Fairmount Cem.,

Location Libertytown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 24 1943 Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24, 1943 19 7:25 A M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/15/43 19 8/24/43 19

and that I last saw him on 8/24/43 19

Immediate cause of death

Peripheral vascular
collapse

Due to

Due to Hemorrhage

Other Conditions Peptic ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Jedore Shingaly M.D.

Address 1401 E. Baltimore Ave. Balto. Md. 8/24/43

G 07531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07531

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 3511 N. Calvert St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3511 N. Calvert St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

ANNIE G. HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife Henry C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1862

8. AGE: Years Months Days If less than one day
80 10 29 hr. min.9. Birthplace Frederica, Del.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John George Melvin

13. Birthplace Frederica, Del.

14. Maiden Name Rebecca MacCauley

15. Birthplace Milford Neck, Del.

16 (a) Informant Mrs. Leona G. Miller

(b) Address 3511 N. Calvert St.

17 (a) Burial (b) Date thereof 8/25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Barratts Chapel
Location Frederica, Del.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 24 1943
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from then 1943 to Aug 22 1943 and that I last saw her alive on Aug 22 1943

Immediate cause of death

Carcinoma
intercurrent
cardiac failure

Due to senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address 1123 8th Ave SE Date signed 8/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN PRINT. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07532
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 6001 High Gate Drive

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6001 High Gate Drive

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Laura Tomms

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Fred Tomms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 1879

8. AGE: Years

64

Months

2

Days

If less than one day

hr.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

at home

FATHER

12. Name

Chas Meredith

MOTHER

13. Birthplace

England

14. Maiden Name

Mary Ann Meredith

15. Birthplace

England

16 (a) Informant

James R. Arthor

(b) Address 6001 High Gate Drive

17 (a)

Burial

(b) Date thereof

8-25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Grain Ridge

Location

Riverside Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

AUG 25 1943

Huntington Williams M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22nd 1943 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from in 1943 to Aug 22 1943, and that I last saw him alive on Aug 22 1943.

Immediate cause of death

Invasive Carcinoma
Due to right breast

Due to

Other Conditions Metastasis

(Include pregnancy within 3 months of death)

Date of operation 1942

Major findings of operation: Cancer

of autopsy: 7 breast

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Mary Bonelli

Address 1113 Federal St

Date signed 8-23-43

Duration

3 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 07533
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3304 Gibbons Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town write RURAL and give town)
(d) Street No. 3304 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Stanley Richardson

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. 717-07-7417

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 16 1894

8. AGE:

Years 68 Months 8 Days 7 hr. min.

9. Birthplace

Baltimore MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Serge Richardson

13. Birthplace

Baltimore MD

14. Maiden name

Thelma

15. Birthplace

Baltimore MD

16 (a) Informant

Mr. Lucile D. Hill

(b) Address

3304 Gibbons Ave

17 (a) Funeral

8/26/43

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore MD

18 (a) Funeral director

William C. Lee

(b) Address

1517 L. Taylor St

19

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1943 at 9:31 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1942 to 8/23 1942, and that I last saw him alive on 8/22 1942.

Immediate cause of death Cerebral Edema

Duration

Due to Arteriosclerosis

Due to

Other Conditions Cardiac hypertrophy

Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold V. Warner
Address 333 E. East Ave. Date signed 8/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Minnie

G 07534

BUESING
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07534

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1943 to Aug 23 1943 and that I last saw him alive on Aug 23 1943

Immediate cause of death

Due to

Due to

Other Conditions

+ Chronic Arteriosclerosis & Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AUG 25 1943

07535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07535
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1501 Cox St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County City

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1501 Cox St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edward A. Watts

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Lydia Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1877

8. AGE: Years 65 Months 8 Days 9 26 hr. min.

9. Birthplace

Md
(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Foreman

12. Name Benjamin Watts

13. Birthplace unknown

14. Maiden Name Bertha Carney

15. Birthplace

16 (a) Informant Marion Walsh

(b) Address 1501 Cox St

17 (a) Burial (b) Date thereof 8/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location 1045 Linden

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 AUG 25 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1943 at 6-9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Aug. 1943 and that I last saw him alive on

Immediate cause of death

Carcinoma of larynx

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Lewis H. Rasmussen

Address 4037 Falls Rd. Date signed 8/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

439965

G 07536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07536

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 516 W. Conaway St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Washington Witherspoon

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/22/43

8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Ellison Witherspoon

13. Birthplace

S. C.14. Maiden Name Reba Huggins

15. Birthplace

S. C.

16 (a) Informant

Records(b) Address JOHNS HOPKINS HOSPITAL17 (a) Burial(b) Date thereof 8-25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ont Lake, Md

Location

Isaiah L. Brown

18 (a) Funeral director

(b) Address

108 W. Montgomery St19 AUG 25 1943

(b)

Washington Williams

Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 231943, at 1.15 M21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1943, to Aug. 23 1943, and that I last saw him alive on Aug. 23 1943.

Immediate cause of death

failureDuration
3 days

Due to

toxemia

Due to

septicemia
dysentery

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert Kaye

Address

114 W. 11th St

Date signed

8-23-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07537
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mo., or days) 2-0-0

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Eislen(c) City Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 434 Belmont Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HERMAN ELLIOTT

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored6 (a) Single, married, widowed, or
divorcedMarried

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

35

Months

Days

If less than one day

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Not known

13. Birthplace

va

14. Maiden Name

Louise Elliott

15. Birthplace

va

16 (a) Informant

Mrs Bessie Robinson

(b) Address

773 George St.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8-27-43

(month) (day) (year)

(c) Cemetery or crematory

Oakwood Cem

Location

Norfolk, Virginia

18 (a) Funeral director

Mrs. James A. Hemmley

(b) Address

W. Biddle St.

AUG 23 1943

(Date rec'd by registrar)

Phyllis Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1943, at 1:35 A.M.21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐, accident ☐, suicide ☐,
homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Multiple
Stab wounds

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury August 23, 1943 at 20 PM(b) Where did injury occur? Frederick and Barrett St(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work? No(d) Means of injury Slashed23. Signature Robert L. Graham M.D.

Medical Examiner.

Date signed August 23, 1943

correct age in especially important

G 07538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07538
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3243 E. Baltimore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3243 E. Baltimore St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

Annie C. Harple

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Charles L. Harple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19th 18678. AGE: Years 75 Months 10 Days 5 If less than one day
hr. min.9. Birthplace Littleton Pennsylvania
(Town, county, and state)10. Usual Occupation at Home

11. Industry or business

12. Name Thomas Bowers13. Birthplace Pennsylvania14. Maiden Name Unknown15. Birthplace Pennsylvania16 (a) Informant Mr. Howard Harple(b) Address 2913 Oakcrest Ave.17 (a) Burial (b) Date thereof 8/27/1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Woodlawn
Location Baltimore Maryland18 (a) Funeral director Wesley M. Pendergast(b) Address 7401 Belair Road19 (a) Huntington, West Virginia (b) 147 E. ...

AUG 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1943 10:40 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to Aug 24 1943 and that I last saw him alive on Aug 24 1943.

Immediate cause of death

myocardial degenerationDue to arteriosclerosis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature J. J. GouldAddress 147 E. ...Date signed 8-25-43 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07539

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day

(e) Length of stay in Baltimore (yrs., mos., or days) - 30

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 701 Bartlett Ave
(If rural give location)(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

George E. Hudgins

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M.

6 (b) Name of husband or wife Ruth Hudgins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24/1894

8. AGE: Years Months Days If less than one day
49 5-4 29 hr. min.9. Birthplace Orange Co., Va.
(Town, county, and state)

10. Usual Occupation Bar Keeper

11. Industry or business Saloon

12. Name George W. Hudgins

13. Birthplace Va.

14. Maiden Name Lucie M.

15. Birthplace Va.

16 (a) Informant Mrs. George Hudgins

(b) Address 701 Bartlett Avenue

17 (a) Burial (b) Date thereof Aug. 25/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Balto., Co., Md.

18 (a) Funeral director Flynn & Flynn

(b) Address 1426 N. High St.

19 (a) AUG 25 1943

(Date of death)

Registered by

H. J. M. M. M.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1943 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1943 to 8/23 1943, and that I last saw him alive on 8/23 1943

Immediate cause of death

Cerebral edema; Cortical lesion
Subarachnoid & Subdural hemorrhage

Due to

Fracture of skull - through base & parieto-occipital region

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy: Same as above.

22. If death was due to external causes, fill in the following: 9/8

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 8/19/43 at Evening M

(c) Where did injury occur? Baltimore, Md.

(d) Did injury occur about home, on farm, industrial place, in public place? 701 Bartlett Ave. City or town (County) (State)

place? at Home in While at work?

(Specify type of place)

(e) Means of injury Fall upon yellow pipe

23. Signature H. Cohen

Address University Hosp. Date signed 8/24/43

Approved by Howard J. M. M. M.

Correct age is especially important. Physicians: please write the cause of death clearly and briefly.

G 07540
JL - 92923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07540
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland.
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 25 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Baltimore
(c) City or town: Baltimore
(d) Street No.: 807 W. Lombard St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Catherine Newbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F 5. Color or race: W 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Raymond Newbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1955
8. AGE: Years: 87 Months: 88 Days: 7 28 hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name: George Raymond

13. Birthplace: Md.

14. Maiden Name: Mary Reed

15. Birthplace: Md.

16 (a) Informant: B. C. H. Records

(b) Address: 4940 Eastern Ave.

17 (a) burial (b) Date thereof: 8/26/1943
(c) Cemetery or crematory: New Cathedral
Location: 1300 Old York Rd.

18 (a) Funeral director: John J. Cowart
(b) Address: 901 N. 3rd St.

19 (a) AUG 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/23 1943 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1943 to 8/23 1943 and that I last saw her alive on 8/23 1943.

Immediate cause of death: Cardiac failure a multiple art. renal thrombi
Due to: Gen. arterio-sclerosis & A.S.C.D.
Due to:

Other Conditions: Semity; early mononucleosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury: E. L. Sengman

23. Signature: B. C. H. Date signed: 8/24

Duration: 3 d.
PHYSICIAN: Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07541

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3411 O, Donnell St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Herman C. Getz.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

M

6 (b) Name of husband or wife Louisa Wiegand

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1867

8. AGE:

Years

Months

Days

If less than one day

76

0

0

hr.

min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name Henry

13. Birthplace

Germany

14. Maiden Name

not known

15. Birthplace

Germany

16 (a) Informant Louisa Getz.

(b) Address 3411 O, Donnell St.

17 (a) Burial (b) Date thereof 8/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

19 AUG 25 1943

Registrar
H. J. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3411 O, Donnell St.

(If rural, give location)

(e) Citizen of foreign country?

NO

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1943, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1943 to Aug. 21, 1943, and that I last saw him alive on Aug. 20, 1943.

Immediate cause of death

myocarditis (chronic)

Duration

?

Due to arteriosclerosis

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Eugene P. Pearson, Jr.

M. D.

Address 514 Irving Lane Date signed 8/23/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07542

CERTIFICATE OF DEATH

G 07542

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Kernan Hospital St. 43 Ward)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. 14 of foreign birth? yrs. mos. da.

2. FULL NAME

(a) Residence: No. 522 Johannson St. St. 17 Ward. (Usual place of abode) (If non-resident give city or town and State)

Registered No. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
If U. S. Veteran specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. Color or Race <u>Col</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
6a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day, year) <u>Sept 23, 1926</u>		
7. AGE Years <u>16</u> Months <u>11</u> Days <u>0</u>	If LESS than 1 day, hrs. or min.	
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>none</u>		
10. Date deceased last worked at this occupation (month and year) <u>0</u>		
11. Total time (years) spent in this occupation <u>0</u>		
12. BIRTHPLACE (city or town) (State or country) <u>Lynchburg Va</u>		
13. NAME <u>Irma Thompson</u>		
14. BIRTHPLACE (city or town) (State or country) <u>Va</u>		
15. MAIDEN NAME <u>Irma Thompson</u>		
16. BIRTHPLACE (city or town) (State or country) <u>Va</u>		
17. INFORMANT <u>Irma Thompson</u> (Address) <u>522 Johannson St</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>Int. Calvary</u> Date <u>Aug 26, 1943</u>		
19. UNDERTAKER <u>George T. D. Sullivan Jr</u> (Address) <u>1735 Morris Hillman</u>		
20. FILED _____ 19 _____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 23, 1943

22. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1943 to Aug 23, 1943
I last saw ~~deceased~~ alive on Aug 23, 1943 Death is said to have occurred on the date stated above, at 7:35 Pm.

The principal cause of death and related causes of importance were as follows:
Hypostatic Pneumonia Date of onset 8-18-43
Aeromonas infection 6-30-43
with abscess formation
Other contributory causes of importance:
Amplaid Disease (P) 7-15-43
Secondary Anemia 12-1-43

Was an operation performed? Yes Date of 1-6-43 3-4-43
For what disease or injury? Catecholamine 12th Rib Rtd.
Name of operation Resection 12th rib Lucas & Davis
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Moses Gellman M. D.
(Address) 1411 Entwistle Place

AUG 25 1943

Registrar

G 07543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97G 07543
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2802 Parkwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2802 Parkwood Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

WILLIAM S. RIEHTLER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Tena Reightler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1861

8. AGE: Years Months Days If less than one day

82

0

6

hr.

min.

9. Birthplace Thurmont, Md

(Town, county, and state)

10. Usual Occupation Retired Miller

11. Industry or business

12. Name David Reightler

13. Birthplace Md.

14. Maiden Name Tabitha Fleagle

15. Birthplace Md

16 (a) Informant Mrs. Luther Smith

(b) Address 2802 Parkwood Ave.

17 (a) Burial (b) Date thereof 8/26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC

(b) Address North & Pa. Aves

19 (a) (b)

(Date rec'd by registrar)

Registrar

AUG 25 1943
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23, 1943, at 9:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11, 1943, to Aug. 23, 1943, and that I last saw him alive on Aug 22, 1943.

Immediate cause of death

Myocardial Failure -
Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE FULLY AND CORRECTLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07544
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 614 Allendale St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 614 Allendale St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

JOHN E. WALSH

3 (b) If veteran, name war

--

3 (c) Social Security Account
No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Jennie R. Walsh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1894

8. AGE: Years Months Days If less than one day
 49 4 20 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Hospital Textiles

12. Name Charles Walsh

13. Birthplace unknown

14. Maiden Name Mary Jane Wills

15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Jannie R. Walsh

(b) Address 614 Allendale St.

17 (a) Burial (b) Date thereof 8/25/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) AUG 25 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1943 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/42 to 8/22/43, and that I last saw him alive on 8/21/43.

Immediate cause of death

Coronary thrombosis

Duration
1 yr.

Due to

Due to

Other Conditions Hypertensive
 cardio vascular disease
 (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Mary Deibel
 Address 1226 Hanover St. Date signed 8/24/1943

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly.
 correct age is especially important.

AUG 25 1943
VS 100

G 07545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07545

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

14

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1943, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943, to Aug 24 1943, and that I last saw him alive on Aug 24 1943.

Immediate cause of death

Coronary vascular collapse

Due to Acute Rheumatic Myocarditis and Pulmonary Emboli

Due to Acute Rheumatic Fever

Other Conditions Mitral Stenosis & insuff., and Aortic Insuff. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed 8/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07546
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1017 Linden Ave.
 (c) Hospital or institution: none
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 17
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County
 (c) City or town Balto.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 531 Oxford St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Maggie Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1885

8. AGE: Years 58 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Clinton N.C.
 (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name Katie Hicks15. Birthplace N.C.16 (a) Informant Mrs. Savannah Edwards16 (b) Address 1111 Harlem Ave.

17 (a) Burial (b) Date thereof 8/26/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Clinton Cemetery
 Location Clinton N.C.

18 (a) Funeral director Adolphus Halstead18 (b) Address 918 Druid Hill Ave.

19 (a) Huntington Williams
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1943, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1943, to Aug. 23, 1943, and that I last saw him alive on Aug. 23, 1943.

Immediate cause of death Hemiplegia
 Due to Intermittent Nephritis
and Hypertension 2 mo

Due to
 Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation noneMajor findings of operation: none

of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? _____ While at work _____
 (Specify type of place)

(e) Means of injury

23. Signature J. T. Gump

John N. Arlington Date signed 8/24/43
 Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 25 1943

G 07547

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07547

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Cathoon + Fayette St*

(c) Hospital or institution:

Franklin Square Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*(e) Length of stay in Baltimore (yrs., mos., or days) *4 yrs.*

3 (a) FULL NAME

Marline P. Reckard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *9-11-39*

8. AGE:

Years

Months

Days

If less than one day

*3**11**13*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

Edward Marline Reckard

13. Birthplace

Balts. Md.

14. Maiden Name

Mary E. Maemiller

15. Birthplace

Balts. Md.

16 (a) Informant

Edward P. Reckard

(b) Address

312 S. Norris St

17 (a)

Burial

(b) Date thereof

Aug 26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London PARK

Location

Balts Md

18 (a) Funeral director

Harry H. Wight

(b) Address

4101 Edmondson Ave.

19 (a)

(b)

Huntington Williams, Md.

AUG 25 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

*312**S. Norris St.*

(If rural give location)

(e) Citizen of foreign country?

No.

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*8-24*19*43*at *6:30* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *8-23* 19*43* to *8-24* 19*43*.and that I last saw her alive on *8-24* 19*43*.

Immediate cause of death

Bronchopneumonia

Duration

Due to

Due to

Other Conditions

Epilepsy?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James E. Goodman

Address

*Franklin Sq. Bldg.*Date signed *8/25/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK, GIVING EVERY ITEM OF INFORMATION. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07548

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2753 Rayner Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr Bryan Stinchcomb

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1866

8. AGE: Years Months Days If less than one day
77 45 12 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired Collector

11. Industry or business Hecht Bros.

12. Name Nelson P. Stinchcomb

13. Birthplace Balto. Md.

14. Maiden Name Rachel Toller

15. Birthplace Baltimore Co

16 (a) Informant Miss Betty E. Stinchcomb

(b) Address 2753 Rayner Ave.

17 (a) Burial (b) Date thereof Aug 27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 E. Annapolis Rd.

19 (a) AUG 25 1943 Huntington Hall

(Date of registration) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943, to Aug 24 1943, and that I last saw him alive on Aug 24 1943.

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other Conditions Benign Prostatic

Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation Aug 16 1943

Major findings of operation: Benign Prostatic

Hypertrophy

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature Jm. Miller Jr.

Address Church Home Hospital

Baltimore Md.

PHYSICIAN

Underline the cause to which death should be charged statistically.

M. D.

Date signed 8-29-43

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07549
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 904 Russell St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baets
(If outside city or town limits, write RURAL and give town)(d) Street No. 904 Russell St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME Verdella Turner

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Fe

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Geo. Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1894

8. AGE: Years Months Days If less than one day

49 HS hr. min.

9. Birthplace

Baets
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George Ben

13. Birthplace

14. Maiden Name Mary Ben

15. Birthplace

16 (a) Informant Rose Perry(b) Address 913 Chestnut St17 (a) Burial (b) Date thereof 8-29-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. AuburnLocation Baets18 (a) Funeral director James A. Hayes(b) Address 142 W. 1st St19 (a) 25 1943 (b) 25 1943
(Date registered) (Date of death)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1943 at 12:05 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1943 to Aug. 23 1943, and that I last saw him live on Aug. 23 1943.Immediate cause of death uremiaDuration 14 daysDue to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Ralph W. RecklingAddress 426 N. Fulton St Date signed 8/25/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE FACTS OF DEATH CLEARLY AND LOGICALLY. Physicians: please write the causes of death clearly and logically. correct age is especially important.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

G 07550
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-05-3683

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 25 1943

(b)

(Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 22 1943, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Aug 22 1943.

and that I last saw him alive on Aug 22 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 day

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07551

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 224 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MattieAikens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

M6 (b) Name of husband or wife Theophilus Aikens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1903

8. AGE:

Years

Months

Days

If less than one day

40

hr.

min.

9. Birthplace

Cambridge, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name William Monokay

13. Birthplace

Md.

MOTHER

14. Maiden Name Rachel Born

15. Birthplace

Md.

16 (a) Informant

Theophilus Aikens

(b) Address

224 N. Calhoun St

17 (a)

Burial

(b) Date thereof

Aug 26 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Cambridge, Md.

18 (a) Funeral director

Chas O. Wilson

(b) Address

1000 Bishop Lay Ave

19 (a)

AUG 25 1943William Monokay

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1943, at 3 AM21. I certify that I took charge of the remains described above, held an Dissection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

BronchialAsthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature

Robert C. Graham M.D.
Medical Examiner.

Date signed

August 23 1943

07552
83202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07552

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Boy Sanders

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1943

8. AGE: Years Months Days If less than one day
6 hr. 10 min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Clarence Hinton

13. Birthplace Md.

14. Maiden Name Mary Sanders

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Cremation (b) Date thereof 9:00 AM 8/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospital
Location 4940 Eastern Ave. Balto. Ind.

18 (a) Funeral director

(b) Address

AUG 25 1943 William H. Williams, Jr.
(Name and address of funeral director)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1943 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8-12 1943 to 8-13 1943
and that I last saw him alive on 8-13 1943

Immediate cause of death

Congenital atelectasis

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. E. Purcell, M.D.

Address Balto City Hosp. Date signed 8-13-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07553

83218 -AB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07553

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **4040 Eastern Ave.**

(c) Hospital or institution:

Baltimore City Hospitals(d) Length of stay in hospital or inst. (yrs., mos., or days) **8 1/2**(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

Md.

(a) State

(b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **305 W. Preston St.**

(e) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Boy Chatman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

O

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 13-1943

8. AGE:

Years

Months

Days

If less than one day

8 1/2

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

John Chatman

13. Birthplace

Va.

MOTHER

14. Maiden Name

Arie Marlow

15. Birthplace

Va.16 (a) Informant **Baltimore City Hospitals**

(b) Address

Records17 (a) **Cremation**

(Burial, cremation, or removal)

(b) Date thereof

8/23/43

(month) (day) (year)

(c) Cemetery or crematory

Baltimore City

Location

Hospitals Eastern Ave.**Baltimore, Md.**

18 (a) Funeral director

(b) Address

AUG 25 1943**Huntington Williams, Jr.**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-1319**43**21. I certify that death occurred on the date above stated; that I attended deceased from **8-13 1943** to **8-13 1943**.and that I last saw him alive on **8-13 1943**.

Immediate cause of death

of the cerebral parenchyma

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Phyllis M. D.

Address

Baltimore City HospitalsDate signed **8-13-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: Please write the cause of death clearly and briefly.

G07554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG07554
Registered No. 3

1. PLACE OF DEATH:

(a) Baltimore ~~City~~ Maryland(b) Street address 6420 Reisterstown Rd.

(c) Hospital or institution:

Mount Hope Retreat(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-8-13(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 818 N. Luzerne Avenue
(If rural, give location)(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME

Sophia M. Neuschaefer

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorcedWidowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1880

8. AGE:

Years

Months

Days

If less than one day

621012

hr.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER12. Name A. J. Voith13. Birthplace Baltimore14. Maiden Name Mary Protzman15. Birthplace Baltimore16 (a) Informant Mount Hope Retreat(b) Address 6420 Reisterstown Rd.17 (a) Aug 12, 1943 (b) Date thereof Burial
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer
Location Balair Road18 (a) Funeral director Charles E. Schumacher(b) Address 2601 E. Madison St.19 (a) 8/11/43 (b) A. W. Hedrick
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1943, at 10:20 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1939 to Aug 9 1943, and that I last saw her alive on Aug 9 1943.

Immediate cause of death

Cerebral thrombus

Due to

Due to

Other Conditions manic depressive psychosis - depressive type
(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at 10

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

23. Means of injury

Signature Samuel P. Hays M. D.Address 336 Baltimore St.

Duration

1 day3 1/2 yrs

PHYSICIAN

Underline the cause in which death should be charged statistically.

correct age is especially important. If uncertain, please state.

G 07555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07555
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address UNION MEM. HOSPITAL
 (c) Hospital or institution 34th AND CALVERT ST
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 0
 (e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
 (c) City or town 1526 Carswell St Baltimore Md
 (d) Street No. (If outside city or town limits, write RURAL and give town)
 (e) Citizen of foreign country? No (If rural give location) (Yes or No)
 If yes, name country

3 (a) FULL NAME

INFANT BOY KOUSOURIS

3 (b) If veteran, name war No

3 (c) Social Security Account No. No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/22/43

8. AGE:

Years

Months

Days

If less than one day

0

0

0

0

hr.

5

min.

9. Birthplace

UNION MEM. HOSP.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

PETE KOUSOURIS

13. Birthplace

Md.

MOTHER

14. Maiden Name

MARY FRENCH

15. Birthplace

Md.

16 (a) Informant

HOSPITAL RECORDS

(b) Address

UNION MEM. HOSP.

17 (a)

Cremation

(b) Date thereof

8-24-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Union Memorial Hospital

18 (a) Funeral director

(b) Address

AUG 25 1943

W. H. Williams, Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-22 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1943 to 8-22 1943, and that I last saw him alive on 8-22 1943.

Immediate cause of death

Duration

IMMATURE BIRTH

Due to

IMMATURE BIRTH.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

No

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

James N. McCosh

Address

Union Memorial Hosp Date signed 8-24-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07556
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street *Monument + Rutland*

(c) Hospital or institution:

Sinai Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*(e) Length of stay in Baltimore (yrs., mos., or days) *13 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County *—*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2200 Arden Road*
(If rural give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country.

3 (a) FULL NAME

Charles J. Dryer

3 (b) If veteran, name war

—

3 (c) Social Security Account

No. *None*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Widower*6 (b) Name of husband or wife *Josephine Dryer*6 (c) If alive, give age *—* years7. Birth date of deceased (mo., day, year) *May 30, 1861*8. AGE: Years *82* Months *2* Days *25* If less than one day
hr. min.9. Birthplace *New York*
(Town, county, and state)10. Usual Occupation *Retired liquor*11. Industry or business *Merchant*12. Name *Henry Dryer,*13. Birthplace *Manchester, England*14. Maiden Name *Amelia*15. Birthplace *Germany*16 (a) Informant *Mrs. Edw. L. Koran,*(b) Address *2200 Arden Road*17 (a) *Burial* (b) Date thereof *8/26/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Har Sinai*Location *Balt. Md.*18 (a) Funeral director *Sinai Hebrew*(b) Address *—*19 (a) *AUG 25 1943* (b) *Indefinite for Williams, Md.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 24, 1943, at 1 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *5/4/1943* to *8/24/1943*, and that I last saw him alive on *8/24/1943*.

Immediate cause of death

*Cushing's*Due to *curious tongue*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Wachman*Address *Sinai Hosp.* Date signed *8/29/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6-02557

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1541 N. Caroline St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LARRY COHEN

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1940

8. AGE: Years Months Days If less than one day

2

87

24

hr.

min.

9. Birthplace Balt. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Paula Cohen

13. Birthplace Balt. Md.

14. Maiden Name Betty Lageraik

15. Birthplace Balt. Md.

16 (a) Informant Paul Cohen

(b) Address 1541 N. Caroline St.

17 (a) (b) Date thereof (month) (day) (year)

(Burial, cremation, or removal)

(c) Cemetery or crematory United Hebrew

Location Washington Blvd.

18 (a) Funeral director Jack Lewis Inc.

Address 1479 E. B'nai St.

19 (a) AUG 25 1943

(Date rec'd by)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1943, at 2:15 M.

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to B Scald, 1st + 2nd degree

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Aug. 19/ 1943 at Noon M.

(b) Where did injury occur? 1541 N. Caroline St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Upset a pot of boiling water.

23. Signature H. J. Williams M.D.

Date signed 8-25-43

07558

83121-A-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07558

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

27 hr. 16 min.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 520 Tramore Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Girl Gillispie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

1 hr.

20 min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Gene Gillispie

13. Birthplace Ohio

MOTHER

14. Maiden Name Marie Taylor

15. Birthplace West Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Cremated (b) Date thereof 8-12-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment Baltimore City Hospitals

Location 4940 Eastern Ave. Balt., Md.

18 (a) Funeral director

(b) Address

AUG 25 1943 (c) Undertaker William H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1943

8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1943, to 8-9 1943 and that I last saw her alive on 8-9 1943.

Immediate cause of death

Intra cranial hemorrhage

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 8-17-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07559

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2425 Arunah Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James O. Moul

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife Lavinia Hollstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1868

8. AGE: Years Months Days If less than one day
74 10 hr. min.

9. Birthplace York, Pa.

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

12. Name Geo. W. Moul

13. Birthplace Pa.

14. Maiden Name --

15. Birthplace --

16 (a) Informant Miss. Helen L. Moul

(b) Address 2425 Arunah Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug. 27, 1943
(month) (day) (year)

(c) Cemetery or crematory Lorraine Cemy.

Location Woodlawn, Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 AUG 25 1943

(b) Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1943 at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 1m to 19
and that I last saw h alive on Jan 19 1943

Immediate cause of death

Chronic Myocarditis

Due to Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

Atherosclerosis

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 622 W. North Ave.

Date signed

Attest by Howard J. Malvern, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07560
439861BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07560

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5500 Normandy Place

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Harold Woolcott Chapin

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 066-10-1256

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife Frances Bedford6 (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) 1-29-18948. AGE: Years 49 Months 6 Days 25 If less than one day hr. min.9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business Standard Oil Co. N. Y.12. Name Dr. Edward Chapin13. Birthplace N. Y.14. Maiden Name Mary Miller15. Birthplace N. Y.16 (a) Informant Records(b) Address JOHNS HOPKINS HOSPITAL17 (a) Cremation (b) Date thereof Aug 26/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium Loudon ParkLocation 3801 Frederick Ave18 (a) Funeral director John Crutcher Sons(b) Address 1906 East Ave19 (a) AUG 25 1943 Registrar

(Date of death) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1943 at 10:19 AM21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1943 to Aug. 24, 1943 and that I last saw him alive on Aug. 24, 1943

Immediate cause of death

Uremia

Duration

2 d.Due to infiltrating carcinoma of urinary bladder 2 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 1943Major findings of operations infiltrating carcinoma of urinary bladderDiagnosis infiltrating carcinoma of urinary bladderDiagnosis of autopsy Uremia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Crutcher SonsAddress 1906 East AveDate signed 8/25/43

PLEASE WRITE FAIRLY, WITH CONFIDENCE AND CORRECTLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07561

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5209 Frankoe Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name and

3 (c) Social Security Account

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1943

8. AGE: Years Months Days If less than one day
6 21 9 hr. 45 min.9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George C. Clabaugh

13. Birthplace Baltimore

14. Maiden Name Margaret Jager

15. Birthplace Baltimore

16 (a) Informant George C. Clabaugh

(b) Address 5209 Frankoe Ave.

17 (a) Burial (b) Date thereof Aug 26 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Maryland Park
Location Baskville, Md.

18 (a) Funeral director Leonard J. Ruppert

(b) Address 5305 Harbor View Rd.

19 (a) (Date) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 5209 Frankoe Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1943 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1943, to Aug. 24 1943, and that I last saw him alive on Aug. 24 1943.

Immediate cause of death

Acute Cardiac Dilatation.
Cyanosis.Due to Diseases
Congenital Cardiovascular

Due to Patent ductus arteriosus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. D. M. D.

Address 6014 York Road Date signed 8-24-43

Duration

Four minutes

since birth

since birth

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. PHYSICIAN: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. CORRECT AGE IS ESPECIALLY IMPORTANT.

G 07562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *30E*

G 07562

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *307 N. Eyster St.*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ethel Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1907

8. AGE:

36

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore, City

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

12. Name

Fredrick Wilson

13. Birthplace

Baltimore City

14. Maiden Name

Goldie Hutchens

15. Birthplace

Baltimore, Md.

16 (a) Informant

Fredrick Wilson

(b) Address

*JOHNS HOPKINS HOSPITAL*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Aug 27 1943

(c) Cemetery or crematory

Int Cal of Country

Location

A A Co. Md.

18 (a) Funeral director

Robert L. Williams

(b) Address

1515 N. Eyster St.

19 (a)

(b) Date of death

AUG 25 1943

(c) Registrar

Huntington Williams, Md.

MEDICAL CERTIFICATION

*30*20. DATE OF DEATH *August 24 1943* at *10 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *August 24 1943* to *August 24 1943* and that I last saw him alive on *August 24 1943*.

Immediate cause of death

Heart failure

Due to

Aortic insufficiency

Due to

Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Richard B. Balun

Address

Madison Ave

Date signed

*8/24/43**1701 Eyster Place*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

7563

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07563

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 25 1943

(b) H. H. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attended deceased from 8/28 1945 to 8/24 1945

and that I last saw him alive on 8/24 1945.

Immediate cause of death

Cardio-vascular

Due to

Due to

Other Conditions

(Include pregnancy and date of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE IN PRINT. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07564
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 1400 - N. Caroline St.
- (c) Hospital or institution: St. Joseph's Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2825 Clearview Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY GIRL DEAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 19428. AGE: Years Months Days less than one day
3 hr. 2 min.9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Everett Deal13. Birthplace North Carolina14. Maiden Name Margaret Sherrill15. Birthplace North Carolina16 (a) Informant Everett Deal(b) Address 2825 Clearview Ave.17 (a) Burial (b) Date thereof Aug 27 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loray Park
Location North Carolina18 (a) Funeral director Leonard J. Rued(b) Address 5105 Maryland RoadAUG 26 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1943 at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1943 to 8-25 1943, and that I last saw him alive on 8-25 1943.

Immediate cause of death

Obstructive jaundice

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury J. B. Palmer

23. Signature

Address

St. Joseph's Hosp. Date signed 8/25/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07565
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1400 9. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md.

(b) County: Anne Arundel

(c) City or town: Brooklyn, Baltimore, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 113 Franklin Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas Leo Buchal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 18, 1942

8. AGE:

Years

Months

Days

If less than one day

1

2

7

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Charles Buchal

13. Birthplace

Balto. Md.

14. Maiden Name

Adele Williams

15. Birthplace

Balto. Md.

16 (a) Informant

Charles Buchal

(b) Address

113 Franklin Ave

17 (a)

Burial

(b) Date thereof

Aug 27

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

Brooklyn, P.A.C.

18 (a) Funeral director

Henry J. Fleming

(b) Address

1416 E. Light St.

AUG 26 1943

Thomas L. Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-1943 at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1943 to 8-25-1943, and that I last saw him alive on 8-25-1943.

Immediate cause of death meningitis

Duration

Due to tuberculosis

8 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

PHYSICIAN

Underline the cause to which death should be charged statistically

of autopsy: Basal meningitis, Pul. Tuberculosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Stanley B. Ryan, M.D.

Address

St. Joseph's Hospital

Date signed 8-25-43

G 07566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07566
830

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 813 S. BOND ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 813 S. BOND ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CHARLES CARL RUND

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 218 07 8326

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOWER

6 (b) Name of husband or wife MARGARET B. RUND

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2 1863

8. AGE: Years Months Days If less than one day

80

6

21

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation RETIRED BUTCHER

11. Industry or business

12. Name CARL RUND

13. Birthplace GERMANY

14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant MARGARET RUND (DAUGHTER)

(b) Address 813 S. BOND ST.

17 (a) BURIAL (b) Date thereof AUG. 26/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory TRINITY CEM.

Location O'DONNELL ST.

18 (a) Funeral director Lilly and Gester, INC.

(b) Address 403 S. WOLFE ST.

19 (a) (b)

AUG 26 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 23 1943 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1943 to Aug. 22 1943, and that I last saw him alive on Aug. 22 1943.

Immediate cause of death

Uremia

Due to

Nephritis (alt)

Due to

Other Conditions Cerebral Thrombosis (?)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Henry Linder

Address 48 W. Broadway

Date signed 8/24/43

Duration

3 days

3 days

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07567
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4114 Marx Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27(e) Length of stay in Baltimore (yrs., mos., or days) 57 YRS.

3 (a) FULL NAME

KATHERINE JAGOZINSKA ALSO KATHERINE GAGODZISKA

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

WIDOW6 (b) Name of husband or wife MICHAEL JAGOZINSKA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 11 18748. AGE: Years Months Days 13 If less than one day68812

hr.

min.

9. Birthplace POLAND

(Town, county, and state)

10. Usual Occupation HOUSE WIFE11. Industry or business AT HOME12. Name UNKNOWN13. Birthplace POLAND14. Maiden Name UNKNOWN15. Birthplace POLAND16 (a) Informant PETER JAGOZINSKA (SON)(b) Address 620 S. BROADWAY.17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof AUG. 27/43

(month) (day) (year)

(c) Cemetery or crematory ST. STANISLAUSLocation DUNDALK AVE.18 (a) Funeral director Lilly and Zeiler INC.(b) Address 403 S. WOLFE ST.19 (a) AUG 26 1943

(Date of registration)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 4114 Marx Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country20. DATE OF DEATH Aug 24 1943 at 2 P. M

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosiscardiovascular disease

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wollanrich M.D.Date signed 8-24-43

G 07568

AB-83359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07568

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**(d) Length of stay in hospital or inst. (yrs., mos., or days) **3 Days**(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1524 Baker St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Johnson

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
M5. Color or race
C6 (a) Single, married, widowed, or
divorced. **Widower**6 (b) Name of husband or wife **?**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 2-1891**8. AGE: Years Months Days If less than one day
72 6 21 hr. min.9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **John Johnson**13. Birthplace **Va.**14. Maiden Name **Ellen ?**15. Birthplace **Md.**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records**17 (a) **Burial** (b) Date thereof **8/27/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **mt Auburn**
Location **md**18 (a) Funeral director **Rev. H. Kelsan**(b) Address **1303 Plessington**19 (a) **AUG 28 1943** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8/23 1943** at **2:50 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **8/20 1943** to **8/23 1943** and that I last saw **him** alive on **8/22 1943**.Immediate cause of death **Coronary failure; meningitis**Due to **H. A-5, C.V. disease, nephrosclerosis**Due to **?**Other conditions **Semiprobable; gen. arteriosclerosis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury **E-L Surgery**Signature **E-L Surgery**Address **BCH** Date signed **8/25**

Duration

2 wk.**?****?****?****?**

PHYSICIAN

Underline the cause to which death should be charged statistically.

?**?**

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07569

BALTIMORE CITY HEALTH DEPARTMENT

G 07569

CERTIFICATE OF DEATH 131a

Registered No.

440034

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County(c) City or town 586 Oxford ST.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Leona M. Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Early

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

6-?-05

8. AGE:

Years

Months

Days

If less than one day

38

2

hr.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Dave M. Cray

13. Birthplace

S.C.

14. Maiden Name

Hester Miller

15. Birthplace

S.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

8/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

Army Ordnance Co. Bldg

18 (a) Funeral director

Adolphus H. Hester

(b) Address

918 S. D. Hill Ave

19 (a)

(Date rec'd by registrar)

(b)

Registrar

AUG 26 1943

H. H. Hester, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1943, 12 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1943, to Aug. 25 1943, and that I last saw her alive on Aug. 25 1943.

Immediate cause of death Uremia

Due to

nephritis

Due to

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Russell A. Nelson

Address

Johns Hopkins Hosp

signed 8/25

Duration
2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07570

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W

6 (a) Single, married, widowed, or divorced

105-12-1864

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-12-80

8. AGE:

Years

Months

Days

If less than one day

63

"

3

13

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and State)

10. Usual Occupation

Car repairman

11. Industry or business

FATHER

12. Name

John Adams Weigand

13. Birthplace

Germany

14. Maiden Name

Bacher Roehel

15. Birthplace

Germany

16 (a) Informant

Chad

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal

Date thereof

8/28/1943

(c) Cemetery or crematory

London Park

Location

3801 Frederick Ave.

18 (a) Funeral director

John E. Coway & Son

(b) Address

901 Hopkins St.

19 (a)

(Date rec'd by registrar)

AUG 26 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/25 1943 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1943 to 8/25 1943 and that I last saw him alive on 8/25 1943

Immediate cause of death Acute heart failure

Duration

Due to

Due to

Other Conditions

Coronary artery disease in bones & lungs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

James A. Smigler

Date signed 8/25/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07571

Registered No.

830

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1022 N. Carrollton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John R. J. Jones

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

M.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 1879

8. AGE:

Years

Months

Days

If less than one day

63

10

hr.

min.

9. Birthplace

King & Queen Co., Va.
(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Tunstall

13. Birthplace

Va.

14. Maiden Name

Charity

15. Birthplace

Va.

16 (a) Informant

Mattie Tunstall

(b) Address

1022 Carrollton Ave.

17 (a)

Burial

(b) Date thereof

8/29/43

(c) Cemetery or crematory

Mt Auburn

Location

18 (a) Funeral director

Mrs. H. Nelson

(b) Address

1303 P. Street

19 (a)

Date of death

AUG 26 1943

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-1943, at 1:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.

23. Signature Howard J. Mulvaney

M.D.

Date signed 8-25-43

Medical Examiner.

G 07572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07572
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1714 Laurens St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1714 Laurens St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

MARY LUCRETIA SULLIVAN

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife. --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1863

8. AGE: Years Months Days If less than one day

80

7

22

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Storekeeper - Conf.

11. Industry or business Own

12. Name Paola Sullivan

13. Birthplace Md.

14. Maiden Name Rachel Haines

15. Birthplace Md.

16 (a) Informant Mr. Wm. A. Sullivan

(b) Address 1714 Laurens St.

17 (a) Burial (b) Date thereof 8/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 26 1943

(b) Date of death

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1943 at 5:4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13, 1942, to Aug. 25, 1943, and that I last saw him alive on Aug. 23, 1943.

Immediate cause of death

Mammary Carcinoma

Duration

3 yrs.

Due to

Due to

Other Conditions

Ch. Valvular
Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Chas. J. Keller

Address

22 N. Monument

M. D.

Date signed Aug 25, 1943

G 07573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07573

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2814 Harford Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2814 Harford Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CHARLES W. McKEWIN

3 (b) If veteran, name war

3 (c) Social Security Account
No. 214 - 16 - 98744. Sex
male5. Color or race
white6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife Mary E. McKewin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1871

8. AGE: Years Months Days If less than one day
71 11 1 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Supt. of Construction

11. Industry or business Housing Authority-U.S.A.

12. Name Richard J. McKewin

13. Birthplace Md.

14. Maiden Name Matilda Growthers

15. Birthplace Md.

16 (a) Informant Mr. James W. McKewin

(b) Address 3106 Acton Rd.

17 (a) Burial (b) Date thereof 8/26/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 26 1943

(b)

VB 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1943 at 5:05A M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 10 1943 to Aug 23 1943.
and that I last saw him alive on Aug 23 1943.

Immediate cause of death Myocardial

Duration

10 days

Due to Myocarditis

Due to Endocarditis

5-76

Other Condition Arterio sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dr. J. J. J. J. J.

Address 9858 Harford Rd. Date signed 8/24/43

Registrar

Buck 07574

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07574
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2 W. 26th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

FRANK OLIVER BUCHMAN

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. 215 - 03 - 3867

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1915

8. AGE: Years

8

Months

2

Days

9

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business Central Insurance Co.

FATHER

12. Name George W. Buchman

13. Birthplace Carroll Co., Md.

MOTHER

14. Maiden Name Lettie M. Perkins

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. G. W. Buchman

(b) Address 2 W. 26th St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

8/28/43

(c) Cemetery or crematory Druid Ridge Com.

Location

Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date of death)

VS 12

AUG 28 1943

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1943, at 12:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1943, to August 25, 1943, and that I last saw him alive on August 24, 1943.

Immediate cause of death Cardiac-respiratory failure

Duration

9 days

Due to Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George L. Murgatroyd, Jr. M.D.
Address 332 E. University Pkwy. signed 8/25/43

G 07575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07575

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2020 Portugal Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2020 Portugal Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

KATHERINE ANDREWS KUCHCZYNSKI (Cook)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

Female

White

Married

6 (b) Name of husband or wife Joseph Kuchczynski

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1883

8. AGE: Years 59 Months 8 Days 4 If less than one day
hr. min.9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name. Michael Hybrzynski

13. Birthplace Poland

14. Maiden Name Anastasia Nowak

15. Birthplace Poland

16 (a) Informant Joseph Kuchczynski

(b) Address 2020 Portugal Street

17 (a) Burial (b) Date thereof 8/28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Sedowski & Sons

(b) Address 1808 Eastern Ave

AUG 26 1943

(Date rec'd by Registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1943 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Nov 1 1942 to Aug 24 1943,
and that I last saw h.c. alive on 8/24 1943

Immediate cause of death

acute cardiac dilatation

Due to

Due to cerebral hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at 4 M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature S C Feldman

Address 440 E Baltimore Date signed 8/25/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07576

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Md.
(c) City or town 426 Hutchins Ave., Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Hutchins Ave., Balto., Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD WAFFORD

3 (b) If veteran, name war
World's War3 (c) Social Security Account
No.4. Sex
Male5. Color or race
Col.6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Alice Wafford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/1892

8. AGE: Years Months Days If less than one day
50 8 30 29 hr. min.

9. Birthplace Harford County, Md.

(Town, county, and state)

10. Usual Occupation Printer - 2 mos ago

11. Industry or business Printing

12. Name Richard Wafford

13. Birthplace Virginia

14. Maiden Name Emily Wren

15. Birthplace Virginia

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Aug 26, 1944

(c) Cemetery or crematory Calb. Nat'l Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Duval Hill Ave.

19 (a) (b)

Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 22, 19 45, at 8:25 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from August 11, 19 43, to Aug. 22, 19 43
and that I last saw him alive on Aug. 22, 19 43.Immediate cause of death Generalized
peritonitisDuration
Several
days

Due to Mesenteric thrombosis

Unk.

Due to

Other Conditions Hypertensive cardio
vascular renal disease

Unk.

(Include pregnancy within 3 months of death)
Date of operation 8/21/43 - Intestinal re-
section & enterostomy
Major findings of operation: Intestinal
obstruction; - Peritonitis
of autopsy: None

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide. NO

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 8/23/43

AUG 26 1943

Huntington Williams, M.D. -13555

07577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07577
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-03-2913

4 Sex

Female

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Walter Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Mathews Virginia

(Town, county, and state)

10. Usual Occupation

Maid

11. Industry or business

12. Name

Anstead Elison

13. Birthplace

Virginia

14. Maiden Name

Mary Bullip

15. Birthplace

Virginia

16 (a) Informant

Frank Hattery

(b) Address

647 N. Calhoun St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8-26-43

(c) Cemetery or crematory

Mathews Va.

Location

Virginia

18 (a) Funeral director

Edith A. Hattery

Address

211 N. Calhoun St.

19 AUG 26 1943

(Date rec'd by registrar)

(b) Hunterdon Williams, MD

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

647 N. Calhoun St.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 25 1943

at

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw him alive on

August 14 1943

Immediate cause of death

Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07578

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1405 N. Longwood St

(c) Hospital or institution:

Mrs. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-0-16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. 1405 N. Longwood St

(d) Citizen of foreign country? (If rural give location)

If yes, name country

3 (a) FULL NAME

Preston R. Hessinger

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex 5. Color or race 6 (a) Single, married, widowed, or

Male White married

6 (b) Name of husband or wife Marie Hessinger

6 (c) If alive, give age 56 yrs

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1887

8. AGE: Years Months Days If less than one day

58 9 7 hr. min.

9. Birthplace Homedale Pa

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Cemetery Co

12. Name William Hessinger

13. Birthplace Pa.

14. Maiden Name Rose Hessinger

15. Birthplace Pa.

16 (a) Informant Mrs. Preston R. Hessinger

(b) Address 1405 N. Longwood St

17 (a) Burial (b) Date thereon Aug 28 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Rose

Location York Pa.

18 (a) Funeral director Max G. Augustine

(b) Address 1701 W. Market St York

19 (a) AUG 26 1943 (b) Date rec'd by registrar

Hessinger William, M.D.

20. DATE OF DEATH 8-26-1943, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractures Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury 8/26/43 at 3:15 A.M.

(b) Where did injury occur? North - on Hill Ave.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public While at work? No

(d) Means of injury Drive a truck full on

23. Signature Howard J. Wallace M.D.

Date signed 8-26-43

(over)

G 07579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07579

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1366 Stockton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m.

5. Color or race

col.

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife Rachell Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1863

8. AGE:

Years

Months

Days

If less than one day

80 yrs

hr.

min.

9. Birthplace Calvert Co. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wesley Cook13. Birthplace Calvert Co. Md.

MOTHER

14. Maiden Name unknown15. Birthplace Calvert Co. Md.16 (a) Informant Rachell Cook(b) Address 1366 Stockton St17 (a) Burial (b) Date thereof 8/28/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arboretum Mem.Location Balt. Co. Md.18 (a) Funeral director Charles H. Hester(b) Address 927 N. Mount St

19 (a)

(b) Date of death AUG 28 1943vs Wesley Cook Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1366 Stockton St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25-1943 at 9 P M21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1943, to 8/25 1943, and that I last saw him alive on 8/25 1943.

Immediate cause of death

Ch. Hepatitis x
uremia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature B. R. Hester

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Please print in ink, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

3 (a) FULL NAME

Kate Miller

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Frederick Miller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15, 1894

8. AGE:

Years

Months

Days

If less than one day

49

3

10

hr.

min.

9. Birthplace

Md., Baltimore

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name Henry Klein

13. Birthplace

Md.

MOTHER

14. Maiden Name Louisa RAPP

15. Birthplace

Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial

(b) Date thereof Aug. 27, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Q. & Co., Md.

18 (a) Funeral director A. J. Hooper & Evans

(b) Address 1400 S. Charles St.

19 (a) AUG 26 1943

H. L. Williams, M.D.

Registrar

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07580

Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 40 E. Heath St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1943, at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1943, to 8/25 1943 and that I last saw her alive on 7/25 1943.

Immediate cause of death

Cardiac failure

Due to Arteriosclerosis (C-4)

Due to

Other Conditions hypertension, arteriosclerosis, and nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no post

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) _____ While at work?

(e) Means of injury

23. Signature E. L. Sigmund, M.D.

Address 13 C. H. Date signed 8/25/43

AB-83422

G 07581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07581

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 616 S. Milton Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Shannon

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Widow

6 (b) Name of husband or wife Joseph (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1864

8. AGE: Years Months Days If less than one day

78

8

5

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Cord

13. Birthplace Baltimore, Md.

14. Maiden Name Annie Heinie

15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records.

17 (a) Burial (b) Date thereof Aug 128/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cn

Location Wingdawn Mill Road

18 (a) Funeral director John J. Welch

(b) Address 401 S. Chester St

AUG 26 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/43 19 4:15 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/24 1943 to 8/25 1943.
and that I last saw her alive on 8/25 1943.

Immediate cause of death:

Pneumonia, lobes, 2
empyema, left.

Due to

Due to

Other conditions: Senility; gen.
interosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury E. J. Sengman

23. Signature

Address B C H

Date signed 8/25/43

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

PLEASE WRITE PLAINLY, WITH OUTFOLDING INK. Every word correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07582
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1610 Ruxton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1610 Ruxton Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mollie Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1873

8. AGE:

Years

Months

Days

If less than one day

70

hr.

min.

9. Birthplace

Russian

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Jacob Hart

13. Birthplace

Russian

14. Maiden Name

Sarah

15. Birthplace

Russian

16 (a) Informant

Harry Green

(b) Address

1610 Ruxton Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Minto Road

Location

Herring Run

18 (a) Funeral director

Jaco Lewis Inc

(b) Address

1439 E. Balt. Rd.

AUG 26 1943

Hastings Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1943 11:00 PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence

(Autopsy or Inquiry)

obtained by said Inquiry find that said deceased came to death on the day stated above.

Immediate cause of death

Chronic Myocardial Degeneration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Hugh B. McCallister

Date signed

8/26/43

Medical Examiner.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07583

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 0

3 (a) FULL NAME

John Fredrick Britner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6/10/19

8. AGE: Years

Months

Days

If less than one day

2 1/2

hr.

min.

9. Birthplace

Harris De Trace, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

John Britner

13. Birthplace

Fort Deposit, Md.

14. Maiden Name

Edith Jackson

15. Birthplace

Fort Deposit, Md.

16 (a) Informant

John Britner

(b) Address

Fort Deposit, Md.

17 (a) Burial

Aug 28, 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Cecil Co., Md.

18 (a) Funeral director

W. J. Patterson, Jr.

19 (a)

Cecil Co., Md.

(Date rec'd by registrar)

H. J. Williams, Jr.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Fort Deposit

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1943 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1943 to Aug. 26 1943 and that I last saw him alive on Aug. 26 1943

Immediate cause of death

Meningitis Pyocyanus

Due to Post-op. Spina Bifida

Due to

Other Conditions Secondary Hydrocephalus

(Include pregnancy within 3 months of death)

Date of operation Aug. 6, 1943

Major findings of operation

Spina Bifida

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. J. Patterson, Jr.

Address

Univ. Hospital

Date signed 8-26

Age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

100 b G 07584

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *John & Lafayette Sts.*

(c) Hospital or institution:

Hospital for Women of Maryland.(d) Length of stay in hospital or inst. (yrs., mos., or days) *11 da.*(e) Length of stay in Baltimore (yrs., mos., or days) *21 yrs 3 mo 20 da*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1438 E. Baltimore St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edith Sandler

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 6 - 1922*

8. AGE:

Years

Months

Days

If less than one day

*21**3**20*

hr.

min.

9. Birthplace *Baltimore, Maryland.*
(Town, county, and state)10. Usual Occupation *Secretary.*

11. Industry or business

FATHER
MOTHER

12. Name

Isaac Sandler

13. Birthplace

Russia

14. Maiden Name

Fanni

15. Birthplace

Russia

16 (a) Informant

Dr. P. P. P.

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

8-26-43
(month) (day) (year)

(c) Cemetery or crematory

Location

*St. Mary's
German Bell Rd.*

18 (a) Funeral director

(b) Address

*Jack Lewis Inc.
1439 E. Balt St.*

UG 26 1943

Huntington Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 26, 1943, at 2:55 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *August 16, 1943* to *August 26, 1943*, and that I last saw him alive on *August 26, 1943*.Immediate cause of death *RESPIRATORY
collapse*

Duration

*13 da.**HYPERTENSION*Due to *SEPTICEMIA - Hemolytic
STREP. following*Due to *Infected emboli from
Phlebitis of Leg & Pelvis*Other Conditions *Atherosclerosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Neeland E. Day*

M. D.

Address *Women's Hospital*Date signed *Aug. 26, 1943*

G 07585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07585

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 N. Payson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1514 N. Payson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Benjamin6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

unknown

8. AGE:

Years

Months

Days

If less than one day

62

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

FATHER
MOTHER

12. Name

Velva

13. Birthplace

Russia

14. Maiden Name

Miriam

15. Birthplace

Russia

16 (a) Informant

Benjamin Tenberg

(b) Address

1514 N. Payson St.

17 (a)

Burial

(b) Date thereof

8-26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Wynona Hill Rd

Location

Town

18 (a) Funeral director

Jack Lewis Inc.1439 E. Balto St

AUG 26 1943

(b)

(Date rec'd by registrar)

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-43 19 3:10 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1943, to Aug 25 1943, and that I last saw him alive on Aug 25 1943.Immediate cause of death Arteritis deformans
Strangulated umbilical hernia
Coronary occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2306 E. EndDate signed 8-26-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

07586

G 07586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1914 Wilkins Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

John J. Walters

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-05-8769

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mildred E. Walters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1896

8. AGE: Years Months Days If less than one day

46

8

5

hr.

min.

9. Birthplace

Ind

(Town, county, and state)

10. Usual Occupation

Blue painter

11. Industry or business

Balto Enamel

FATHER

12. Name

Wm

Walters

13. Birthplace

md

MOTHER

14. Maiden Name

Mary

Walter

15. Birthplace

Md.

16 (a) Informant

wife Mildred E. Walters

(b) Address

1914 Wilkins Ave

17 (a)

Burial

(b) Date thereof 8 25 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto Ind.

18 (a) Funeral director

Robt G. B. Walters

(b) Address

121 S. Stricker St.

19 (a)

Huntington Williams

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1943 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1943 to 8/25 1943

and that I last saw him alive on 8/25 1943

Immediate cause of death

Possible pulmonary embolism

Due to

myocardial infarction

Due to

pulmonary edema

Other Conditions

B. coli Sepsis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. Chen

Address

University Hosp. Date signed 8/25/43

Duration

?

2

2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 26 1943

G 07587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

07587

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Anne Arundel

(c) City or town

St Margaret's - Annapolis

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Alfred Macey

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

Agnes J. Macey

6 (c) If alive, give age

49 years

7. Birth date of deceased (mo., day, yr.)

Feb 15 - 1886

8. AGE:

Years

Months

Days

If less than one day

63

6

11

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

D

11. Industry or business

FATHER

12. Name George Macey

13. Birthplace England

MOTHER

14. Maiden Name Charlotte Purbeck

15. Birthplace England

16 (a) Informant

Agnes J. Macey

(b) Address

St Margaret's Rd

17 (a) Burial

(b) Date thereof

Aug 28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Margaret's

Location

St Margaret's Rd

18 (a) Funeral director

D. H. H. H. H.

(b) Address

Annapolis - Md.

19 AUG 26 1943

(b)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/26 1943, at 2:43 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1943, to 8/26 1943, and that I last saw him alive on 8/26 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Coronary Sclerosis; Myocardial Infarction

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. C. C. C.

Address

University Hospital

Date signed

8/26/43

PLEASE WRITE PLAINLY, WITH CORRECT AGE IS ESPECIALLY IMPORTANT. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 07588	
CERTIFICATE OF DEATH		Registered No. G 07588	
439498		528	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address (c) Hospital or institution: <u>JOHNS HOPKINS HOSPITAL</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>7</u> (e) Length of stay in Baltimore (yrs., mos., or days)		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Fla.</u> (b) County (c) City or town <u>Miami Beach</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>4167 N. Bayside Rd.</u> (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country	
3 (a) FULL NAME <u>Bessie C. Williamson</u> 3 (b) If veteran, name war <u>W</u> 3 (c) Social Security Account No. <u>None</u> 4. Sex <u>Female</u> 5. Color or race <u>White</u> 6 (a) Single, married, widowed, or divorced <u>Widowed</u> 6 (b) Name of husband or wife 6 (c) If alive, give age years 7. Birth date of deceased (mo., day, yr.) <u>10-20-62</u> 8. AGE: Years <u>80</u> Months <u>10</u> Days <u>5</u> If less than one day hr. min. 9. Birthplace <u>Indiana</u> (Town, county, and state) 10. Usual Occupation 11. Industry or business		MEDICAL CERTIFICATION 20. DATE OF DEATH <u>August 25, 1943</u> at <u>10 PM</u> <u>55</u> 21. I certify that death occurred on the date above stated; that I attended deceased from <u>Aug. 1, 1943</u> to <u>Aug. 25, 1943</u> , and that I last saw <u>her</u> alive on <u>Aug. 25, 1943</u> . Immediate cause of death <u>Bladder Tumor</u> <u>Invasion of Intestine</u> Due to Due to Other Conditions	
12. Name <u>Alpheus Coffin</u> 13. Birthplace 14. Maiden Name <u>Charlotte Snider</u> 15. Birthplace <u>Ohio</u> 16 (a) Informant <u>Reverend</u> (b) Address <u>JOHNS HOPKINS HOSPITAL</u> 17 (a) <u>Burial</u> (b) Date thereof <u>8/26/43</u> (c) Cemetery or Crematory <u>Spring Grove</u> Location <u>Cincinnati Ohio</u> 18 (a) Funeral director <u>W. H. Jones</u> (b) Address <u>1217 H. Gould</u> 19 (a) <u>AUG. 26 1943</u> (b) <u>Huntington, W. Va.</u>		PHYSICIAN Underline the cause to which death should be charged statistically. Date of operation <u>8/15/43</u> <u>Colon</u> Major findings of operations <u>inoperable</u> of autopsy <u>vesical-squamous carcinoma</u> 22. If death was due to external cause, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence at M (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? (e) Means of injury 23. Signature <u>James A. Singiser</u> Address <u>J. H. Hospital</u> Date signed <u>8/26/43</u>	

G 07589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07589
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1314 W. Belvedere Ave.
(c) Hospital or institution: -

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 W. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

William Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
M5. Color or race
W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sallie A. Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1860

8. AGE: Years 82 Months 11 Days 22
If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name James Fields

13. Birthplace Ireland

14. Maiden Name Mary

15. Birthplace Ireland

16 (a) Informant R. Alan Fields Jr
(b) Address 1312 W. Belvedere Ave

17 (a) Burial (b) Date thereof 8/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glynmalira
Location My Lady's Manor

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) (b) *Thurston Williams*
(Date rec'd by registrar)

AUG 26 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1943 at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Aug 14 1943, and that I last saw him alive on Aug 27 1943.

Immediate cause of death

Atherosclerotic CVD
with Pericarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lawrence H. Hume

Address 3711 Falls Rd M. D. Date signed 8-25-43

Duration

2 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH EXPANDING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07590

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07590

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *John + Lafayette Sts.*

(c) Hospital or institution:

Hospital for Women of Maryland(d) Length of stay in hospital or inst. (yrs., mos., or days) *15 da*(e) Length of stay in Baltimore (yrs., mos., or days) *Lifetime*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Lake Drive + Park Avenue*

(If rural give location)

(e) Citizen of foreign country? *No*

(Yes or No)

If yes, name country

3 (a) FULL NAME

Irene Landburg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

67 1 27

If less than one day

hr. min.

9. Birthplace

Baeth. Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 26 1943

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 26, 1943* at *3:30 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *August 12, 1943* to *August 26, 1943*, and that I last saw her alive on *August 25, 1943*.Immediate cause of death *Cardio-Respiratory Failure*Duration
*18 da.*Due to *Pulmonary Edema, Cardiac Failure*Due to *Pneumonia, Arteriosclerosis, Heart disease & Myocarditis*Other Conditions *None*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Newland E. Day*Address *Women's Hospital*Date signed *8-26-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. T. Immelle
Med. Bldg.
511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07591
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 909 North Bentall St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

3 (a) FULL NAME

4 Mary Anna Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Harry A. Wagner

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 30-1889

8. AGE: Years Months Days If less than one day

54 8 2526 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

12. Name Peter Rosenberger

13. Birthplace France

14. Maiden Name Catherine Weiler

15. Birthplace Alsace Lorraine

16 (a) Informant Harry A. Wagner

(b) Address 909 N. Bentall St.

17 (a) Burial (b) Date thereof Aug 28-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md.

18 (a) Funeral director George A. Farley

(b) Address Fulton Ave & Fayette St

19 (a) AUG 28 1943 (b) Huntington Williams, MD

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 909 Bentall St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1943, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1943, to Aug. 26 1943,

and that I last saw him alive on Aug. 24 1943.

Immediate cause of death

Carcinoma of breast.

Duration 10 weeks

Due to

Due to

Other Condition Metastases

to liver.

(Include pregnancy within 3 months of death)

Date of operation June 19, 1943

Major findings of operation:

Carcinoma right breast.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dr. T. Immelle

Address Medical Bldg. Date signed 8/28/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G. 07592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 6

G. 07592

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 533 Richmond Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

William E. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife Nellie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 17th 1897

8. AGE: Years 45 Months 11 Days 8 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry Baltimore Shipyard

12. Name Joseph Hopkins

13. Birthplace Md.

14. Maiden Name Grace Miller

15. Birthplace Md.

16 (a) Informant Nellie Hopkins

(b) Address 533 Richmond Ave

17 (a) Burial (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mount Pleasant

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

AUG 26 1943

VB 124

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1943 to 8/25 1943, and that I last saw him alive on 8/25 1943

Immediate cause of death

Meningitis (meningococcal)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Meningitis; Meningococcus; Sepsis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N. Cohen

Address Univ. Hosp

Date signed 8/26/43

Duration

acute

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07593

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (Baltimore)

(d) Street No. 58 Broadship Road

(e) Citizen of foreign country? No (Yes or No)

3 (a) FULL NAME

Willie Florence Sessums

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife David Sessums

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Mar 7 - 1870

8. AGE: Years 73 Months 5 Days 19 hr. min.

9. Birthplace

Miss.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

Ira Jackson

13. Birthplace

Miss.

14. Maiden Name

Mary Ann Tripp

15. Birthplace

Miss.

16 (a) Informant

W. Roy Mackay

(b) Address

58 Broadship Rd.

17 (a) Removal

(b) Date thereof 8/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or burying place

Leona

Location

Mississippi

18 (a) Funeral director

William Cook Inc

(b) Address

1317 St. Paul St

19. Signature

William Cook

20. Date of death

Aug 26 1943

21. Signature

William Cook

22. Signature

William Cook

23. Signature

William Cook

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/43 19 at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1943, to 8-26 1943, and that I last saw her alive on 8-26 1943.

Immediate cause of death

Lobar Pneumonia

Duration

1 day.

Due to Fracture right femur.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accidental fall

(b) Date of occurrence 8-28-43 11:30 AM

(c) Where did injury occur? Broadship Rd. Baltimore Md

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home - Baltimore, While at work? No

(Specify type of place)

(e) Means of injury Accidental fall - slipped

23. Signature Charles R. McDonald

Address 1213 Light St Date signed 8-26-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07594

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Balti.*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *4151 Frederick Ave.*
(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day

9. Birthplace *Baltimore Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

AUG 26 1943

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 25 1943 at 11:50 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 2 1943* to *Aug 25 1943* and that I last saw him alive on *25 Aug 43*

Immediate cause of death

Immediate post-operative death following lobectomy

Due to *st. lower lobe of lung*

Due to *bronchiectasis*

Other Conditions

None

(Include pregnancy within 3 months of death)

Date of operation *Aug 23 1943*

Major findings of operations *Bronchiectasis*

st. lower lobe

of autopsy: *No contributory findings*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *A. J. Ruzicka Jr.*

Address *University Hosp.* Date signed *8/25/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07595
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *London & Green Sts.*

(c) Hospital or institution:

Univ. Hosp. Balt. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rose Kingsbury

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife *Albert T. Kingsbury*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

71 70

9. Birthplace

Md.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Geo. Walter

13. Birthplace

Penn.

14. Maiden Name

Charalle Reid

15. Birthplace

Md.

16 (a) Informant

Albert T. Kingsbury

(b) Address

Savage Md.

17 (a) Burial

(b) Date thereof

Aug 28 1943

(c) Cemetery or crematory

Laurel Md.

18 (a) Funeral director

Lloyd Fisher

(b) Address

Laurel Md.

AUG 27 1943

(Date rec'd by registrar)

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County *Howard*

(c) City or town *Savage*

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/25

19 *43* at *2:45* M

21. I certify that death occurred on the date above stated, that I attend-

ed deceased from *8/4* 19*43* to *8/25* 19*43*

and that I last saw him alive on *8/25* 19*43*.

Immediate cause of death

Pulmonary Edema

Due to *Congestive*

Heart Failure

Due to *Hypertension*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *L. J. Lynch*

Address *Univ. Hosp. Balt. Md.*

Date signed *8/26/43*

Duration

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

67596

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution:

Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2425 Lakeview Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Harris Michael Farbman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife Mrs. Harris M. Farbman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1875

8. AGE: Years Months Days If less than one day

68

2

27

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business Lumber Business

FATHER

12. Name David Farbman

13. Birthplace Russia

MOTHER

14. Maiden Name Fannie Milon

15. Birthplace Russia

16 (a) Informant Jack Farbman

(b) Address 2425 Lakeview Ave

17 (a) Burial

(b) Date thereof August 27, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem

Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

AUG 27 1943

(Date rec'd by registrar)

Washington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1943 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1943, to Aug. 26 1943 and that I last saw him alive on Aug. 25 1943.

Immediate cause of death Carcinoma - respiratory failure

Due to Carcinoma of the lung

Due to

Other Conditions Chronic asthma, cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Mungatunga, Jr. M.D.
Address 332 E. University Pkwy Date signed 8/26/43

Duration

8 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07597
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

URBAN FRANKIE WICZ

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/8/1912

8. AGE:

Years

Months

Days

If less than one day

70

71

11

25

hr.

min.

9. Birthplace

ZAROWKA-AUSTRIA -

(Town, county, and state)

10. Usual Occupation

- LABORER.

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

SISTER MARY HYACINTH

(b) Address

725 CAN ST
FRANCISCAN SISTERS

17 (a)

(b) Date thereof

8/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

ST STANISLAUS

Location

O'Donnell & Dundalk rd

18 (a) Funeral director

Stephen J. Koleski

(b) Address

1000 P. Kennedy Ave

19

AUG 27 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 25 1943 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Aug 19 1943 and that I last saw him alive on Aug 20 1943

Immediate cause of death

Cancer Hypertension

Due to

old heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Leo J. Koleski

Address 1265 P. Kennedy Ave

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07598

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, limited write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 27 1943

Registrar

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07599

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07599

Registered No.

131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1263 William St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *24*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1263 William St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Emma Taylor

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F. m

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *Jan 30 1938*

8. AGE: Years Months Days If less than one day
85- 6 28 24 hr. min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

House work at home

11. Industry or business

FATHER

12. Name *Egriel Taylor*

13. Birthplace *Va*

MOTHER

14. Maiden Name *Fancy E. Callahan*

15. Birthplace *W. Va*

16 (a) Informant *Miss Edith Cook*

(b) Address *1308 Light St*

17 (a) *Burial* (b) Date thereof *8/27/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Int. Olivet*

Location *Frederick Ave*

18 (a) Funeral director *William M. Mareck*

(b) Address *715 Light St*

19 (a) *AUG 27 1943* (b)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 24* 19*43* at *3:40* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Jan NY 19* to *Aug 24 1943* and that I last saw her alive on *Aug 24 1943*

Immediate cause of death

Due to *Heart failure (Circulatory)*

Due to *High blood pressure*

Other Condition *Chronic nephritis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Thos. B. Williams* M. D.

Address *1434 E. Baltimore Ave*

Duration

*Refuse
6 hrs*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07600

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2043 Cliftwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

3 (a) FULL NAME

Esdras O Albers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1868

8. AGE: Years 74 25 Months 10 Days 78 hr. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

12. Name William Albers

13. Birthplace Va

14. Maiden Name Catherine

15. Birthplace MD

16 (a) Informant Mary E Albers

(b) Address 2043 Cliftwood Ave

17 (a) Burial (b) Date thereof 12/20/43

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director William M. March

(b) Address 715 E. 41 St

19 AUG 27 1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2043 Cliftwood Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1943 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1943 to Aug 25 1943 and that I last saw him alive on Aug 24 1943

Immediate cause of death: Curcuma of heart, and Reckless

Due to

Due to

Other Condition: Cardiac Dilatation 30 days

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature: Albert Eisenberg Address: 2025 Church St Date signed: 8/26/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07601
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 Rogers Ave

(c) Hospital or institution:

Home for the Aged of the Methodist Church

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Rogers Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary A. Van Sant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10th 1851

8. AGE:

Years

Months

Days

If less than one day

92

5

15

hr.

min.

9. Birthplace

Balto. Co. Md.

(Town, county, and state)

10. Usual Occupation

Invalid

11. Industry or business

Home for the Aged

FATHER

12. Name

Nicholson Van Sant

13. Birthplace

Carroll Co. Md.

MOTHER

14. Maiden Name

Sallie Hood

15. Birthplace

Carroll Co. Md.

16 (a) Informant

Home for Aged Methodist Church

(b) Address

2211 Rogers Ave

17 (a)

Burial

(b) Date thereof

8/22/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Asbury M. E. Church

Location

Restonstown Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. Paul St.

19 (a)

AUG 27 1943

Huntington

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25th 1943 6²⁵ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1942 to Aug 24 1943, and that I last saw her alive on Aug 24 1943.

Immediate cause of death

Myocardial infarction

Duration

2 days

Due to

arteriosclerosis

10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Arthur J. Davis

Address

800 W 38th St

Date signed

8-26-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07602

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Greene*

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *7 wks.*

3 (a) FULL NAME

Chester Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/9/43

8. AGE:

Years

Months

Days

If less than one day

7 weeks 16

hr.

min.

9. Birthplace *Balt. Md.*

(Town, county, and state)

10. Usual Occupation *Infant*

11. Industry or business

12. Name *Chester Cheatham*

13. Birthplace *South Carolina*

14. Maiden Name *Emma Smith*

15. Birthplace *Virginia*

16 (a) Informant *Emma Smith*

(b) Address *507 Welcome Alley*

17 (a) *Burial* (b) Date thereof *Aug 8/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Calvary*

Location *A.A.C. Md.*

18 (a) *AUG 27 1943* *Joseph L. Brownson*

(b) Address *108 Montgomery Street*

19 (a) (b) *Dr. William H. H. H.*

V8 184

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Balt.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *507 Welcome Alley*

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/25* 1943, at *2:45* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *8/21* 1943, to *8/25* 1943, and that I last saw him alive on *8/25* 1943.

Immediate cause of death

Respiratory failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Josephine E. Renshaw*

Address *Univ. Hospital*

Date signed *8/25/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07603

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4403 Glenarm Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Glenarm Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY CATHERINE THOMAS

3 (b) If veteran, name war
NO

3 (c) Social Security Account
No. NONE

4. Sex
F

5. Color or race
W

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife William Herbert
Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1870

8. AGE: Years Months Days If less than one day
73 10 21 hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

12. Name Jacob Geller

13. Birthplace Germany

14. Maiden Name Riddle

15. Birthplace Germany

16 (a) Informant Mrs. Wm. R. Thomas

(b) Address 3429 Mayfield Ave.

17 (a) Burial (b) Date thereof 8/28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

AUG 27 1943

(Date rec'd by registrar)

Trustington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1943, at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 17 to 1943, to Aug 27 1943.
and that I last saw him alive on Aug 23 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address W. Overman Date signed 8/26/43

Duration

2 yrs.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

07604

BALTIMORE CITY HEALTH DEPARTMENT

G 07604

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Prince George(c) City or town Mitchellville, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M.6 (b) Name of husband or wife William B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1884

8. AGE: Years Months Days If less than one day

586119hr.min.9. Birthplace Howard Co., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Wm. H. Davis13. Birthplace Carroll Co., Md.14. Maiden Name Annie E. Griffith15. Birthplace Howard Co., Md.16 (a) Informant Louis D. Davis(b) Address 703 Washington Ave., Towson17 (a) Burial (b) Date thereof 8/28/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Oak Cem.Location Mitchellville, Md.18 (a) Funeral director Foreaker Funeral Home(b) Address Mitchellville, Md.AUG 27 1943(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1943, at 4 P M21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1943, to 8/26 1943, and that I last saw him alive on 8/26 1943.

Immediate cause of death

Uremia & AnoxiaDue to Hypertensive CVD.Chronic vascular nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. CohenAddress Univ. Hosp. Date signed 8/26/43 M.D.

Duration

1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07605

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mrs. Katherine Hermanau

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 17 1913

8. AGE:

Years

Months

Days

29

11

9

If less than one day

hr.

min.

9. Birthplace

Baltimore Co

(Town, county, and state)

10. Usual Occupation

Sales lady

11. Industry or business

FATHER

12. Name

John E. Hall

13. Birthplace

Balto County

MOTHER

14. Maiden Name

Edith Maglietti

15. Birthplace

Balto Co

16 (a) Informant

Mrs Edith Hall

(b) Address

8106 Bon. Air Rd.

17 (a)

Burial

(b) Date thereof

Aug 30 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Sadlers

Location

Balto County

18 (a) Funeral director

Leonard G. Ruck

(b) Address

5305 Haddon Rd.

19

AUG 27 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

Baltimore

(c) City or town

Baltimore Parkville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

8106 Bonair Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 26 1943 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1943 to Aug. 26 1943, and that I last saw her alive on Aug. 26 1943.

Immediate cause of death

Miliary Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William H. Lusting

Address

St. Joseph's 107

Date signed

8-26-43

G 07606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07606

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 713 Edmondson Ave
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

M.

6 (b) Name of husband or wife

Aminie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1900

8. AGE:

Years

Months

Days

If less than one day

43

hr.

min.

9. Birthplace

Robinson Cr. N.C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Sandy Smith

13. Birthplace

N.C.

14. Maiden Name

Silla Smith

15. Birthplace

N.C.

16 (a) Informant

Sandy Smith Jr.

(b) Address

713 Edmondson Ave

17 (a)

Burial

(b) Date thereof

8/29/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Beechwood

Location

Durham N.C.

18 (a) Funeral director

Eloy D. Wilson

19 (a)

AUG 27 1943

(b)

(Date rec'd by registrar)

Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/251943, 11 40 PM21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Rheumatic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Thurston Williams

Date signed

8/25/43

Medical Examiner.

G 07607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07607
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4914 Chalquore Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 27

(e) Length of stay in Baltimore (yrs., mo., or days) 45 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Balto (b) County

(c) City or town Ind

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4914 Chalquore Ave

(e) Citizen of foreign country? (If rural give location) (Yes or No)

If yes, name country

3 (a) FULL NAME

Fannie Carp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Hyman Carp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1885

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Joseph -

13. Birthplace

Russia

14. Maiden Name

Martha

15. Birthplace

Russia

16 (a) Informant

Philip Carp

(b) Address

2450 Calverly Ave

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof 8-27-43

(c) Cemetery or crematory

Reseda

Location

Philadelphia, Pa.

18 (a) Funeral director

Joe Davis Inc

(b) Address

439 E. Balto. St

19 (a)

(b)

Huntington Williams, Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-43 19 4 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1942 to 8/27 1943 and that I last saw her alive on 8/27 1943.

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertensive disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Huntington Williams

Address 2225 London Date signed 8/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 02608
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ROSE WASSERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Isadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1883

8. AGE:

Years

Months

Days

If less than one day

60

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

House Work

11. Industry or business

12. Name

Not Known

13. Birthplace

Russia

14. Maiden Name

Not Known

15. Birthplace

Russia

16 (a) Informant

Hosp. Records

(b) Address

17 (a) Burial

(b) Date thereof 8-29-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Powder Mill

Location

Phil. Rd. & Hamilton Ave

18 (a) Funeral director

Isadore Shorofsky

(b) Address

1439 E. Baltimore St

19 (a)

(b)

Huntington Williams

(Date rec'd by registrar)

Registrar

AUG 27 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1617 Moreland Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/27/43

19

11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/43 19 to 8/27/43 19

and that I last saw her alive on 8/27/43 19

Immediate cause of death

Respiratory failure

Due to

generalized metastasis

Due to

Melanocarcinoma of skin of heel

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Isadore Shorofsky M.D.

Address West Baltimore Hosp Date signed 8/27/43

Duration

1

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07609

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07609
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

Seven

years

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

AUG 87 1943

Huntington Halliwell, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07610

440150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07610
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 707 Dolphin St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Fred McCullom

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-78

8. AGE: Years

65

Months

6

Days

18

If less than one day

hr. min.

9. Birthplace

West Indies

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

McCullom

13. Birthplace

?

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Aug 30
(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

18 (a) Funeral director

James A. Sings

(b) Address

142 W. N. St

19 (a)

(b)

AUG 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1943, at 125 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1943, to Aug. 26 1943, and that I last saw him alive on Aug. 26 1943

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertensive
Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(a) Means of injury

23. Signature James A. Sings

Address J. H. Hopkins Date signed 8/26/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07611

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 916 N. Bradford St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph M. Konrad

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Sophia Josephine

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

9/25/1874

8. AGE:

Years

Months

Days

If less than one day

68

3

11

80

hr.

min.

9. Birthplace

Bohemia

(Town, county, and state)

10. Usual Occupation

Tailor

11. Industry or business

FATHER

12. Name

UNKNOWN

13. Birthplace

MOTHER

14. Maiden Name

UNKNOWN

15. Birthplace

Prague

16 (a) Informant

Joseph M. Konrad

(b) Address

916 N. Bradford St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8 28 '43

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director

Frank Cyach & Son

(b) Address

900 N. Chester St.

19

(b)

AUG 27 1943

William M. Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 916 N. Bradford St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1943, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943, to Aug 25 1943, and that I last saw him alive on Aug 25 1943.

Immediate cause of death

Uremia

Due to

arteriosclerosis

Due to

hypertension
phlegmasia
venitica

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph M. Konrad
Address 2613 E. Monument Date signed 8/26/43

(OVER)

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G 07612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07612

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 17 E. Barney St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 17 E Barney St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

Nellie Clewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1899

8. AGE:

Years

Months

Days

If less than one day

64

hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 28 1943 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) AUG 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1943 at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 Aug 25 1943, and that I last saw her alive on Aug 24 1943.

Immediate cause of death

acute dilatation of heart

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 64 W Hanover

Date signed 8/26/43

Duration

2 days

Physician

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07613

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address CAROLINE & OLIVER ST.

(c) Hospital or institution:

ST. JOSEPH HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3716 MT. PLEASANT ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CHARLES J. SCHNEIDER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife ELIZABETH SCHNEIDER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 24 1884

8. AGE: Years

58

Months

11

Days

1

If less than one day

hr.

min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation CITY LABORER

11. Industry or business BALTO. CITY

12. Name UNKNOWN

13. Birthplace GERMANY

14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant MARIE KRAFT (DAUGHTER)

(b) Address 302 FOLCROFT AVE.

17 (a) BURIAL (b) Date thereof AUG. 28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE. EXT.

18 (a) Funeral director Gilly & Geiter Inc.

(b) Address 403 S. WOLFE ST.

Aug 27 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1943 at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1943 to Aug 25 1943 and that I last saw him alive on Aug 25 1943.

Immediate cause of death Peritonitis

Duration

Due to Corporation of sigmoid

Due to Intestinal obstruction & Edema & distention of intestine

Other Conditions - Corporation of sigmoid
Band of an old sigmoidal hernia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations As above

of autopsy: Refused

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Hughes

Address St. Joseph Date signed 8/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07614

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1929 GOUGH ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1929 GOUGH ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

HENRY ENGELHARDT

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOWER

6 (b) Name of husband or wife ALICE ENGELHARDT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 6 1858

8. AGE: Years

Months

Days

If less than one day

85

6

19

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation

RETIRED

11. Industry or business

FATHER
MOTHER

12. Name UNKNOWN ENGELHARDT

13. Birthplace GERMANY

14. Maiden Name LENA KLAUSNER

15. Birthplace GERMANY

16 (a) Informant JOHN ENGELHARDT (SON)

(b) Address 1202 EDISON HIGHWAY

17 (a) BURIAL (b) Date thereof AUG. 28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MT. CARMEL

Location O'DONNELL ST.

18 (a) Funeral director Lilly and Geiler, Inc.

(b) Address 403 S. JONES ST.

19 (a)

Registrar

AUG 27 1943

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH AUG. 25 19 43 at 9/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16, 1943, to Aug. 25, 1943, and that I last saw him alive on Aug. 20, 1943.

Immediate cause of death

Acute myocardial infarction
arteriosclerosis

Due to

Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. J. Sullivan M. D.

Address 432 S. Baltimore St. Date signed 8/26/43

Duration

29 +

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48a

G 07615
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1500 2nd Ave Road

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

No

3 (a) FULL NAME

Mrs. Enola Purnell (ENOLA-Mowbray-Purnell)

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Separated

6 (b) Name of husband or wife. W. Raby Purnell

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1892

8. AGE: Years Months Days If less than one day

21

7

12 11

hr.

min.

9. Birthplace Maryland-Carlin Creek-Dorchester

(Town, county, and state)

Co.

10. Usual Occupation

None

11. Industry or business

NONE

FATHER

12. Name

THEOPHILUS A. Mowbray

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Angelina Williams

15. Birthplace

Maryland

16 (a) Informant Mrs. A. Wilson (Sister)

(b) Address 1200 N. Ave, Baltimore

17 (a) BURIAL

(b) Date thereof 8-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Washington

Location

Hurlock, Dorchester Co. Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address

(B. F. WOODEN BLDG.) 108 W. NORTH AVENUE

19 (a) AUG 27 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1943, to Aug 27 1943, and that I last saw her alive on Aug 26 1943.

Immediate cause of death

Carcinoma of uterus & extension

Due to

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Isabella Harrison

M. D.

Address Church Home & Hospital Date signed 8-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07616

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address West Baltimore General
(c) Hospital or institution: Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County -----
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Ednor Road, Ednor Gardens
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME

LOUELLA GEAR (LUELLA ELIZABETH GEAR)

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife William D. Gear

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1886

8. AGE: Years Months Days If less than one day
56 9 16 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business housewife

12. Name William H. Elphring

13. Birthplace Baltimore, Md.

14. Maiden Name M. Adelaide Fisher

15. Birthplace Baltimore, Md.

16 (a) Informant William D. Gear (husband)

(b) Address 3600 Ednor Road, Baltimore, Md.

17 (a) Burial (b) Date thereof 8/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Maryland

18 (a) Funeral director STEWART & MUWEN COMPANY

(b) Address (W. F. WOODEN BLDG.) 100 W. NORTH AVENUE

19 (a)

AUG 27 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/43 19 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/43 19 to 8/27/43 and that I last saw her alive on 8/27/43

Immediate cause of death

Cardiac failure

Due to

arteriosclerotic CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature I. Sborofsky, M.D.

Address West Baltimore

Date signed 8/27/43

Sborofsky

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07617
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *6420 Reisterstown Road*

(c) Hospital or institution:

Mount Hope Retreat(d) Length of stay in hospital or inst. (yrs., mos., or days) *17-0-10*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *808 N. Carey Street*
(If rural give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna Carlin

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1870

8. AGE: Years Months Days If less than one day

73

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

factory hand

11. Industry or business

12. Name

Mathew Carlin

13. Birthplace

Maryland

14. Maiden Name

Ellen O'Brien

15. Birthplace

Not Known

16 (a) Informant

Mount Hope Retreat

(b) Address

*6420 Reisterstown Road*17 (a) *Burial*

(b) Date thereof

Aug-28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Peters Ceme.

Location

Baltimore, Md.

18 (a) Funeral director

Stewart & Brown Co

(b) Address

128 W. North Avenue

19 (a)

AUG 27 1943

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 26, 1943, at 3 A. M.*21. I certify that death occurred on the date above stated; that I attended deceased from *March 1935*, to *Aug. 26, 1943*, and that I last saw her alive on *Aug. 26, 1943*.

Immediate cause of death

Acute circulatory collapse

Due to

Due to

Other Conditions *Cerebral arteriosclerosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *NE*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. J. P. Hagan
Address *33 W. North Avenue* M. D.

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07618

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 07618**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1213 Light St.**
(c) Hospital or institution: **South Baltimore General Hosp.**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **1**
(e) Length of stay in Baltimore (yrs., mos., or days) **1**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **Jeffrey**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **817**
(e) Citizen of foreign country **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME

Baby Girl Dunnant.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. **40** min.

9. Birthplace **Balto. Md.**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Ellis Dunnant**

13. Birthplace **Charlotte Co. Va.**

14. Maiden Name **Lillian Berry**

15. Birthplace **Rice Va.**

16 (a) Informant **Ray French**

(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location **UNIVERSITY MEDICAL SCHOOL AUG 27 1943**

18 (a) Funeral director **Commissioner of Health**

(b) Address

19 (a) **AUG 27 1943** **Huntington Williams, M.D.**
Date of death Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8-25-43** 19 **at 10:45 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **8-25-43** 19 **to 8-25-43** 19 **43**, and that I last saw her alive on **8-25-43** 19 **43**.

Immediate cause of death
anaphylaxis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Charles A. McDonald** M. D.

Address **1213 Light St.** Date signed **5-25-43**

Duration
1 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G 07619
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Univ. Hospital

(c) Hospital or institution:
Balt., Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

3 (a) FULL NAME

Baby Girl Boldo

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/43

8. AGE: Years

Months

Days

If less than one day

12 hr.

min.

9. Birthplace Univ. Hospital Balt. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George Bivins

13. Birthplace Md.

MOTHER

14. Maiden Name Vivian Boldo

15. Birthplace So. Car.

16 (a) Informant Vivian Boldo

(b) Address 125 N. Carrollton Ave.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 27 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 27 1943 (Date rec'd by registrar) Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 125 N. Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1943 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1943 to 8/21 1943, and that I last saw her alive on 8/21 1943.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Josephine E. Renshaw

Address Univ. Hospital

Date signed 8/23

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07620

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No. 215-12-8593

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at

12:30

P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Date signed

August 23 1943

M.D.

Medical Examiner.

AUG 27 1943

H. H. Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07621
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3112 W. Garrison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edmund Heiner Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Georgia L. Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/20/79

8. AGE:

Years

Months

Days

If less than one day

64

4

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

Dorson Chemical Co.

12. Name

John Hoffman

13. Birthplace

Balto. Md.

14. Maiden Name

Rebecca Hartzell

15. Birthplace

Balto. Md.

16 (a) Informant

Mrs. Georgia Louise Hoffman

(b) Address

3112 W. Garrison Ave

17 (a)

Burial

(b) Date thereof

8-28-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine Cemetery

Location

Woodlawn Maryland

18 (a) Funeral director

Loring Byrd

(b) Address

3005 Park Heights Ave.

19 (a)

August 27 1943

20 (a)

H. H. Hoffman

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Balto.

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3112 W. Garrison Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1943 at 11:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1943 to 8/27 1943 and that I last saw him alive on Aug. 27 1943.

Immediate cause of death

1) - Retg. - Pritomel
Sarcoma

Due to

Due to

Other Conditions -

(Include pregnancy within 3 months of death)

Date of operation

6/10/43

Major findings of operation:

Sarcoma

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Earl H. Chambers

Address

4108 Liberty Hts. A.

Date signed

8/27/43

Duration

6 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07622
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2116 Mc Culloch st*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *5 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *2116 Mc Culloch st*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Malissa Frankie Blake

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex *F*

5. Color or race *Col*

6 (a) Single, married, widowed, or divorced *Widow*

6 (b) Name of husband or wife *Woodford*

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *4-25-1873*

8. AGE: Years *69* Months *70* Days *11* If less than one day
hr. min.

9. Birthplace *Somerset County Md*
(Town, county, and state)

10. Usual Occupation *House work*

11. Industry or business

12. Name *George Sterling Md*

13. Birthplace

14. Maiden Name *Caroline Moore*

15. Birthplace *Md*

16 (a) Informant *Sarah Sterling*

(b) Address *2116 Mc Culloch st*

17 (a) *Burial* (b) Date thereof *8-29-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Winfield Md*
Location *Somerset County*

18 (a) Funeral director *William A. Jackson*

(b) Address *916 Penna Ave*

AUG 27 1943

Wm A Jackson

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-25-1943* at *5:15 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *12-7-1938* to *8-25-1943*, and that I last saw her alive on *8-25-1943*.

Immediate cause of death *Cerebral accident*

Due to *Arteriosclerotic hypertension*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *C.R. Campbell, M.D.*

Address *718 Dolphin St* Date signed *8-26-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07623

Registered No.

1. PLACE OF DEATH: *Man*
(a) Baltimore City, Maryland
(b) Street address *Morris Hill ave*
(c) Hospital or institution: *South Baltimore General Hosp.*
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) *8 yrs*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County *Anne Arundel*
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. *Morris Hill ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME *Major Boyer*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *M.* 5. Color or race *Cal* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Helen*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *7-24-1883*

8. AGE: Years *60* Months *1* Days *2* If less than one day
hr. min.

9. Birthplace *Ga.*
(Town, county, and state)

10. Usual Occupation *Laborer*

11. Industry or business

FATHER 12. Name *unknown*
13. Birthplace
MOTHER 14. Maiden Name *Juvenia?*
15. Birthplace *Ga*

16 (a) Informant *Helen Boyer*
(b) Address *Morris Hill ave*

17 (a) *Burial* (b) Date thereof *8-30-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *MT. Calvary Cem*
Location *A. A. County Md*

18 (a) Funeral director *William A. Jackson*
(b) Address *916 Penna ave*

19 (a) *AUG 27 1943* Registrar
Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-26* 19*43*, at *7:45 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *7-27* 19*43*, to *8-26* 19*43*, and that I last saw him alive on *8-26* 19*43*.

Immediate cause of death

Bronchopneumonia

Due to *malnutrition*
senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Paul D. Lubato* M.D.
Address *1213 Light St.* Date signed *8/27/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 07624
131W Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3406 Chestnut Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balt.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3406 Chestnut Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Frances Ward

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or
divorced Widowed

6 (b) Name of husband or wife W. Milton Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1852

8. AGE: Years Months Days If less than one day
91 6 4 hr. min.

9. Birthplace Manchester, Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

None

12. Name Curtis Martin

13. Birthplace Carroll Co. Maryland

14. Maiden Name Elizabeth Brown

15. Birthplace Carroll Co. Maryland

16 (a) Informant Mrs. Grace Sprinkle

(b) Address 6516 Mt. Vernon Ave.

17 (a) Burial (b) Date thereof 8-28-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director Loring Owens

(b) Address 5005 Park Heights Ave.

19 (a) AUG 28 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1943 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 18 1943 to Aug 25 1943
and that I last saw her alive on Aug 25 1943.

Immediate cause of death Uremia

Due to Cardiovascular renal
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature W. N. McFarley

Address 1800 N. Charles St. Date signed 8/27/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07625
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1604 W. Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

4 yrs.

3 (a) FULL NAME

Kathleen T. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 12, 1921

8. AGE: Years

22

Months

2

Days

4

If less than one day

hr.

min.

9. Birthplace

Roanoke Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Marshall T. Harris

13. Birthplace

Virginia

14. Maiden Name

Mary F. Thomas

15. Birthplace

Virginia

16 (a) Informant

Marshall T. Harris

(b) Address

1604 W. Pratt St

17 (a) Signature

Signature

(b) Date thereof

Aug 27/43

(If burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

Roanoke Va

18 (a) Funeral director

Harry N. Shultz

(b) Address

4401 E. Edmonson Ave.

19 AUG 28 1943

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1604 W. Pratt St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 26, 1943. 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb, 1941, to Aug 26, 1943, and that I last saw her alive on Aug 26, 1943.

Immediate cause of death

Broncho pneumonia

Duration

24 hrs

Due to

Acute Infective Enteritis

1 wk

Due to

Chronic Generalized Eczema 19 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. J. Bayless

Address

1600 Wilkins Ave

Date signed

8/27/43

07626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07626
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caroline + Oliver St.*

(c) Hospital or institution:

St. Joseph's Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *27*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME *George GRANVILLE YOUNG*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

*w*6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband or wife

Bessie N. Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 29-1889

8. AGE: Years

Months

Days

If less than one day

*52**53**87**27*

hr.

min.

9. Birthplace

Maryland.

(Town, county, and state)

10. Usual Occupation

Conductor

11. Industry or business

Bath. Transit Co

12. Name

Noah Young

13. Birthplace

Md.

14. Maiden Name

Mary Pusey

15. Birthplace

Md.

16 (a) Informant

Bessie N. Young

(b) Address

*4311 York Rd.*17 (a) *Burial*

(b) Date thereof

Aug 30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Salisbury Md.

18 (a) Funeral director

John A. McKen

(b) Address

*4301 Greenmount*19 (a) *Aug 28 1943*(b) *Thurston Williams, M.D.*

(Date rec'd by registrar)

(Signature)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

*4311**York Rd*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Aug 26*19 *43*, at *9:45**P.M.*

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions *no*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause ofdeath, fill in the following: *03-00*(a) Date of injury *8-25-43* at *2:30 P.M.*(b) Where did injury occur? *Street car junction, old**stage rd*

(c) Did injury occur at home, on farm, industrial place, in public

place? *public* While at work? *yes*(d) Means of injury *Pedestrian struck by street**car*Signature *H. W. Hollenback* M.D.Date signed *8-27-43*

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67627

Previti
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67627

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

315 East St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

36 7 2

3 (a) FULL NAME

Vincent Previti

3 (b) If veteran, name war

NO

3 (c) Social Security Account No.

NOPE

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

White

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 26 1892

8. AGE:

Years

Months

Days

If less than one day

70

11

1

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER

12. Name

Salvatore Previti

13. Birthplace

Italy

MOTHER

14. Maiden Name

Louise (Muhanna)

15. Birthplace

Italy

16 (a) Informant

Mrs. Janina Previti

(b) Address

315 East St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

6/30/43

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore Md

18 (a) Funeral director

Thompson & Son

(b) Address

1217 St Paul St

19 (a) Date rec'd by registrar

AUG 28 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write R.R. and give town)

(d) Street No.

315

East St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1943 at 10 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18, 1943 to Aug 27, 1943, and that I last saw him alive on Aug 26, 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

9 days

Due to

Arteriosclerosis

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Ernest S. Pearson

M. D.

Address 514 Inverness Lane

Date signed 8/27/43

07628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07628

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4218 Connecticut Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4218 Connecticut Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Frederick William Garter

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

White

Married

6 (b) Name of husband or wife

Eatherine Garter

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr)

April 27th 1872

8. AGE:

Years

Months

Days

If less than one day

71

3

29

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Architect

FATHER

12. Name

Francis X. Garter

13. Birthplace

Germany

MOTHER

14. Maiden Name

Christie Georgie

15. Birthplace

Pittsburg Pa

16 (a) Informant

Victoria T. Garter

(b) Address

4218 Conn. Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8/28/43

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 St Paul

(c) Date rec'd by registrar

August 28 1943

(d) Signature

Huntington Williams

VB 158

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 26th 1943 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1943 to 8/26 1943 and that I last saw him alive on 8/26 1943

Immediate cause of death

Chronic Coronary Disease

Due to Cause of Strained

Due to with metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Joseph H. Lauterbach

Address

679 Washington

Date signed 8/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67629

AMEREIHN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67629

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *St. Joseph's Hospital*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 mos*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William H. Ameriehn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Loretta K.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 3rd 1886*

8. AGE: Years Months Days If less than one day
56 10 24 hr. min.

9. Birthplace *Balto., Md.*

(Town, county, and state)

10. Usual Occupation *Conductor*

11. Industry or business *Balto. Transit Co.*

12. Name *Henry Ameriehn*

13. Birthplace *Balto Md.*

14. Maiden Name *Unknown*

15. Birthplace " "

16 (a) Informant *Agar T. Ameriehn*

(b) Address *1820 Disquith St*

17 (a) *Burial* (b) Date thereof *8/21/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer*
Location *Balto Md.*

18 (a) Funeral director *Wm Cook Inc.*

(b) Address *1217 St. Paul St*

AUG 28 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1820 Disquith St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 27 1943* at *7 50* M

21. I certify that death occurred on the date above stated; that I attended deceased from *4/25/43* 19 to *8/27/43* and that I last saw him alive on *8/27/43*

Immediate cause of death *Dehydration*
Cachexia

Due to *Sarcomatous Metastasis*

Due to *Carcinoma of Rectum - sigmoid*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Dec. 21, 1942*

Major findings of operations: *As above - Inoperable*

of autopsy: *Agar*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *William H. Ameriehn*

Address *St. Joseph's Hospital* Date signed *8/27/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07630

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07630
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Franklin Square Hospital*

(c) Hospital or institution:

100 N. Calhoun St

(d) Length of stay in hospital or inst. (yrs., mos., or days) *25*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Balto (Brooklyn)*
(If outside city or town limits, write RURAL, and give town)

(d) Street No. *1125 Monroe Circle*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Lloyd Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) *Jan 18th 1941*

8. AGE: Years Months Days

1 *7* *8* *8* hr. min.

If less than one day

9. Birthplace

Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John L. Pruitt

13. Birthplace

Crisfield Md.

14. Maiden Name

Ruth Sebbons

15. Birthplace

Balto. Md.

16 (a) Informant

Ruth Pruitt

(b) Address

1125 Monroe Circle

17 (a) *Burial*

(b) Date thereof *8/30/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 St. Paul St

19 (a) *AUG 28 1943*

(b) *Huntington Williams, Md*

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 26* 1943, at *7²⁶* P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Chronic Emphysema
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *W Wallace Wakeley*

Address *422 Mulberry St*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 02631

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1314 Homestead St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

2nd

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1314 Homestead

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Elmer Henry Stridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Sarah C. Stridge

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Aug 21 - 1890

8. AGE:

Years

Months

Days

If less than one day

53

0

5

hr.

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual Occupation

Cook

11. Industry or business

B & O R.R.

FATHER

12. Name

Patrick Joseph Stridge

13. Birthplace

Ireland

MOTHER

14. Maiden Name

Catherine Hunt

15. Birthplace

Balto Md.

16 (a) Informant

Catherine Stridge

(b) Address

1314 Homestead St

17 (a)

Burial

(b) Date thereof

8/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 St. Paul St.

AUG 28 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 26

19

43

30

M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1943 to Aug 26 1943 and that I last saw him alive on Aug 26 1943.

Immediate cause of death

Myocardial Reg. decomposed

Due to

Myocardial lesion

arterio sclerosis

Due to

Chc. Pneumonia

myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2878 Harford Rd

Date signed 8/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07632

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 7:43 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/24 1943 to 8/27 1943.

and that I last saw her alive on 8/27 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 8/28/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

G 07633
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2818 Rosalie Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME

ANNA T. HOCHSTEDT

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Alfred O. Hochstedt
6 (c) If alive, give age 18 yrs

7. Birth date of deceased (mo., day, yr.) March 5, 1878

8. AGE: Years 64 Months 05 Days 22 If less than one day
hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Adam Biensach

13. Birthplace Germany

14. Maiden Name Elizabeth Hartman

15. Birthplace Unknown

16 (a) Informant Mrs Katherine Biensach

(b) Address 2818 Rosalie Ave.

17 (a) burial (b) Date thereof Aug. 30, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Passador Funeral Home

(b) Address 7401 Belair Road

AUG 28 1943

VS 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Rosalie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943 at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1943 to Aug 27 1943 and that I last saw her alive on Aug 27 1943.

Immediate cause of death

Rheumatic Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George Sawyer

Address 4808 Harford Rd. Date signed Aug 27, 43

Duration
Underline the cause to which death should be charged statistically.

PHYSICIAN

Underline the cause to which death should be charged statistically.

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07634
59488

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07634
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Clarkson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

Annie Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Herman Griffith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1858

8. AGE: Years Months Days If less than one day

84

11

7

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
MOTHER

12. Name William Littleton

13. Birthplace Md.

14. Maiden Name Elizabeth Bell

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof Aug. 28, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director J. Howard Evans

(b) Address 1400 S. Charles St.

19 AUG 28 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1943, 2:14 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1941, to Aug 26, 1943, and that I last saw him alive on Aug 26, 1943.

Immediate cause of death

Bronchopneumonia

Duration

17 days

Due to Pat operative

Due to Aspiration & Hypertension

Other Conditions Volvulus of

Large Bowel

(Include pregnancy within 3 months of death)

Date of operation Aug. 3, 1943

Major findings of operations: Volvulus of Ascending & Sigmoid Colon of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. G. Pierpont M. D.
Address Balto. City Hosp Date signed Aug 26, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07635
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1372 N. Carey St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Sandra Campbell Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

J. J. Person

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 7, 1875

8. AGE: Years

67

Months

11

Days

18

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(City, county, and state)

10. Usual Occupation

Teacher

11. Industry or business

Public schools

12. Name

John Campbell

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Emma Haller

(b) Address

1372 N. Carey St.

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

Aug 25, 1943

(c) Cemetery or crematory

Put. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

Mr. George H. Hollan

(b) Address

1621 W. 1st St. Baltimore

AUG 28 1943

VS 144

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1372 N. Carey St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/25

1943, 11:35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/1943 to 8/25/1943

and that I last saw her alive on 8/24/1943

Immediate cause of death

Carcinoma of Breast

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. Biddle

8/28/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07636

47a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3335 Payne St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3335 Payne St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM ARNOLD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife. Helen G. Arnold

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1887

8. AGE: Years 58 Months 10 Days 29
If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Textile Worker.

11. Industry or business I. I. O.

12. Name Geo. Arnold

13. Birthplace Md.

14. Maiden Name Mary Ruby

15. Birthplace Md.

16 (a) Informant Helen G. Arnold

(b) Address 3335 Payne St.

17 (a) Burial (b) Date thereof Aug 30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chambers & Dawson

(b) Address 7615-17 Chestnut Ave.

19 AUG 28, 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1943, at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of larynx.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. J. Williams, M.D.

Date signed 8-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07637

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07637
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 523 S Paca Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 - 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Clarence H Hall

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-10-2934

4. Sex

Male

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Arnita

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 28 1910

8. AGE: Years

33

Months

3

Days

27

less than one day

min.

9. Birthplace

Baltimore Ind

(Town, county, and state)

10. Usual Occupation

Labr

11. Industry or business

MOTHER FATHER

12. Name Hensley Hall

13. Birthplace Balto Ind

14. Maiden Name Hennetta Griffin

15. Birthplace Balto Ind

16 (a) Informant Arnita Hall

(b) Address 523 S Paca Street

17 (a) Burial

(b) Date thereof Aug 27 43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt Calvary

Location

A.A. Co. Ind

18 (a) Funeral director David L Brown Son

(b) Address 108 W Montgomery Street

AUG 28 1943

V8 100

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 523 S. Paca St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/25 1943 at 11:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1943 to 8/25 1943 and that I last saw him alive on 8/24 1943.

Immediate cause of death

Chronic Valvular Heart Disease
acute pulmonary edema

Due to

History of leprosy in
Other Conditions: Leprosy 1943;
syphilis not cured.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. Jackson
128/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

638

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07638

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 0

3 (a) FULL NAME

Allen Greene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1943

8. AGE: Years

Months

Days

If less than one day

6 hr. 41 min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name

Vernon Burke

13. Birthplace

Maryland

14. Maiden Name

Shirley Greene

15. Birthplace

Maryland

16 (a) Informant Hospital Records

(b) Address Johns Hopkins Hospital

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL AUG 28 1943

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 28 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 W. Franklin Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1943, 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1943 to August 16, 1943 and that I last saw him alive on August 16, 1943.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Philip P. Steptoe, M.D.

Address Johns Hopkins Hospital Date signed 8-19-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

39

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07639

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 28 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Lutherville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 21

1943-3-29

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1943 to Aug 21 1943.

and that I last saw h. alive on Aug 21 1943.

Immediate cause of death

Cardiac failure

Duration

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07640
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 W. Franklin Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Albert Greene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1943

8. AGE:

Years

Months

Days

If less than one day

4 hr. 30 min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Vernon Burke

13. Birthplace

Maryland

14. Maiden Name

Shirley Greene

15. Birthplace

Maryland

16 (a) Informant

Hospital Records

(b) Address

Johns Hospital Hospital

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL AUG 28 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19 (a)

AUG 28 1943 - Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1943 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1943, to August 16, 1943, and that I last saw him alive on August 16, 1943.

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Philip P. Steptoe, Jr.

M. D.

Address Johns Hopkins Hospital Date signed 8-19-43

07641

G 07641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200 C

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 908 Madison Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 908 Madison Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Martha Rae Jeray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

0 0 0 23 hr. 20 min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Boyce Grant Jeray

13. Birthplace Florence, S.C.

14. Maiden Name Mary Eliza Brown

15. Birthplace Florence, S.C.

16 (a) Informant Mary Eliza Jeray

(b) Address 908 Madison Ave.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 28 1943

18 (a) Funeral director Commissioner of Health

19 (a) AUG 28 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1943, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 P.M. 8/12 1943, to 4 P.M. 8/12 1943, and that I last saw her alive on 8/12 1943.

Immediate cause of death

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy ~~No~~ Yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address University Hosp. Date signed 8/13/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1239 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 Hanover
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Ludwig

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race white 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cath. Honora Lewis 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8-1903

8. AGE: Years 40 Months 18 Days 18 hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Car Cleaner

11. Industry or business

12. Name John Ludwig

13. Birthplace Austria

14. Maiden Name Evelyn P.

15. Birthplace Austria

16 (a) Informant Mrs. C. Ludwig

(b) Address 1239 Hanover St.

17 (a) Burial (b) Date thereof 8/30/43 (c) Cemetery or crematory Sacred Heart

(d) Location German Hill Rd.

18 (a) Funeral director John J. Foley

(b) Address 318 Light St.

19 (a) AUG 28 1943 (b) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1943, 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/1943 to 8/26/1943 and that I last saw him alive on 8/26/1943.

Immediate cause of death Multiple sclerosis

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Deiter

Address 1226 Hanover St. Date signed 8/27/1943.

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07643

Registered No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>Md.</u> (b) County <u>none</u>	
(b) Street address <u>2 W. 39th St.</u>		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution: <u>none</u>		(d) Street No. <u>2 W. 39th St.</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>12</u>		(e) Citizen of foreign country? <u>no</u> (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days) <u>life</u>		If yes, name country.	

3 (a) FULL NAME Ellen J. Poudor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife George Harry Poudor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1866

8. AGE: Years 77 Months 6 Days 4 5 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Francis Owings

13. Birthplace Wales

14. Maiden Name Mary McCormick

15. Birthplace Scotland

16 (a) Informant George H. Poudor

(b) Address 2 W. 39th St.

17 (a) Burial (b) Date thereof 8/28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John A. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

AUG 28 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 Aug 27 1943 and that I last saw her alive on Aug 27 1943.

Immediate cause of death

Cerebral arterio sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel

Address Medical Arts Bldg.

Date signed 8/28/43

Duration

5 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1400 R Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1387 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Mary Agnes Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 26 1925

8. AGE:

Years

Months

Days

If less than one day

18

3

0

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Kelly

13. Birthplace

Balto Md

14. Maiden Name

Alma Roth

15. Birthplace

Baltimore Md

16 (a) Informant

Joseph Kelly

(b) Address

1387 N Milton Ave

17 (a)

Burial

(b) Date thereof

Aug 30 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

New Baltimore

Location

Old Frederick Rd

18 (a) Funeral director

John G. Jackson

(b) Address

307 E. Baltimore

AUG 28 1943

Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1943 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943 to Aug 26 1943 and that I last saw her alive on Aug 26 1943.

Immediate cause of death

Diabetic Coma

Due to

Diabetes Mellitus

Due to

Old Pancreatic Nephrosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?

(e) Means of injury

23. Signature

Dr. S. A. Stevens

Address

2878 Harford Rd

Date signed 8/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Duration

1 1/2

Free

1/4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07645

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3139 Dudley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 28 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 26, 1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943, to Aug. 26, 1943, and that I last saw her alive on Aug. 26, 1943.

Immediate cause of death

Myocarditis

Due to Atelectasis (3 times) and Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Eugene S. Passafium

M. D.

Address 514 Duquesne Lane

Date signed 8/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07646

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 28 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1109 W. Cross St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *0 yrs.*

3 (a) FULL NAME

Amelia Necker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

late John J. Necker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 18, 1862

8. AGE: Years Months Days

81 3 8

If less than one day

hr. min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Albert Fisher

13. Birthplace

Germany

14. Maiden Name

unknown

15. Birthplace

Germany

16 (a) Informant

Mr Charles Necker

(b) Address

2687 Dulany St

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

8/30/43

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balt. Md

18 (a) Funeral director

Harry H. Wither

19 (a) *101 E. Lombard St*

(Date rec'd by registrar)

August 29 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore Md*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1109 W. Cross St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1943

at *M*

21. I certify that death occurred on the date above stated that I attend-

ed deceased from *Jan 1, 1944* to *Aug 27, 1943*.

and that I last saw *her* alive on *Aug 22 1943*.

Immediate cause of death

Acute Heart Failure

Due to *Chronic Myocarditis*

Due to *-*

Other Conditions *- Arteriosclerosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature *Louis J. Glass*

Address *876 W. Lexington St*

City *Baltimore Md*

State *Md*

Date signed *8/28/43*

Physician

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07648

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *101 S. Catherine St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

William H. Roff

3 (b) If veteran, name war

3 (c) Social Security Account

No. *219-01-1558*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife *Alice A. nee*

M. Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 2, 1884*

8. AGE: Years Months Days If less than one day

59 5 24 hr. min.

9. Birthplace *Baltimore Md*

(Town, county, and state)

10. Usual Occupation *Laborer*

11. Industry or business *Eastern Rolling Mills*

12. Name *Charles H. Roff*

13. Birthplace *Maryland*

14. Maiden Name *Sophie Scheidt*

15. Birthplace *Maryland*

16 (a) Informant *Mrs. Alice A. Roff*

(b) Address *101 S. Catherine St*

17 (a) *Burial* (b) Date thereof *8/20/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *London Park*

Location *Baltimore Md.*

18 (a) Funeral director *Harry H. Wither*

(b) Address *4101 E. Madison Ave.*

(Date rec'd by registrar) (b) *Huntington Williams, M.D.*

23. Signature

Address *620 W. 30th St*

Date signed *Aug 29 1943*

5. USUAL RESIDENCE OF DECEASED:

5. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *101 S. Catherine St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 26 1943 12:00 PM*

21. I certify that death occurred on the date above stated; that I attended

deceased from *Jan 27 1937* to *Aug 26 1943*

and that I last saw him alive on *Aug 25 1943*

Immediate cause of death

CORONARY OCCLUSION

Due to *ARTERIO-SCLEROSIS*

Due to

Other Condition *BRONCHIAL ASTHMA*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following: *no*

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature *Edward J. Melan M.D.*

Address *620 W. 30th St*

Date signed *Aug 29 1943*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07649
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 528 Wellesley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Walter L. Doring

3 (b) If veteran, name war

3 (c) Social Security Account
No. 213-09-1261

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1898

8. AGE: Years Months Days If less than one day

45 6 2 hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

12. Name Charles Doring

13. Birthplace Balto. Md.

14. Maiden Name Jenna Stockett

15. Birthplace Balto. Md.

16 (a) Informant Mr. Charles Doring

(b) Address 528 Wellesley Ave.

17 (a) Burial (b) Date thereof 8/31/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory West Rest

Location Balto. Md.

18 (a) Funeral director Harry H. White

(b) Address 4101 E. Lombard Ave.

Washington, D.C.

AUG 29 1943 (b) Register

(Date rec'd by registrar) (Signature)

VS 160

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 528 Wellesley Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943 to Aug 28 1943, and that I last saw him alive on Aug 28 1943.

Immediate cause of death

Coronary of the heart

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Albert Korman

Address 1934 Wellesley Ave Date signed 8/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07650650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07650
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 105 Sorento Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

3 (a) FULL NAME

John F. Kidd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Madelene H. nee Ritz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1890

8. AGE: Years Months Days

53

8

21

If less than one day

hr.

min.

9. Birthplace

New York

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

Social Security

12. Name

John Kidd

13. Birthplace

N. Y.

14. Maiden Name

Catherine Reilly

15. Birthplace

N. Y.

16 (a) Informant

Mrs. John F. Kidd

(b) Address

105 Sorento Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug 30/43

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Balti. Md.

18 (a) Funeral director

Harry H. Hitzke

(b) Address

410 E. Madison Ave.

AUG 29 1943

(b)

John Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore Maryland

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

105 Sorento Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1943 at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1943 to 8-27 1943, and that I last saw him alive on 8-26 1943.

Immediate cause of death

Carcinoma of stomach

Due to

Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

5/15/43

Major findings of operations

Inoperable Carcinoma

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. H. Hitzke

Address

4309 4th Ave

Date signed

M. D.

8-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07651

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

3 (a) FULL NAME

Edward Ruth

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1907

8. AGE: Years 35 Months 11 Days 26 If less than one day hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Ruth

13. Birthplace Md.

MOTHER

14. Maiden Name Louise Schleupner

15. Birthplace Canada

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof 8/30/43 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Location Baltimore Md.

18 (a) Funeral director George G. Farley

(b) Address 1111 1/2 Fayette St.

AUG 29 1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County BALTIMORE

(c) City or town Baltimore ROGERS FURGE (If outside city or town limits, write RURAL and give town)

(d) Street No. 400 Overbrook Road

(e) Citizen of foreign country? No (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1943 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22/43 to 7/26/43 and that I last saw him alive on 7/26/43.

Immediate cause of death Septicemia Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sargison

Address B C H Date signed 8/27

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07652
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *West Baltimore General Hospital*

(c) Hospital or institution:

Rayner & Dukeland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *40 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1815 Baker St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EMANUEL BICKMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Ether

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE: Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Barber

FATHER
MOTHER

12. Name

Nathan Bickman

13. Birthplace

Russia

14. Maiden Name

Sophia Bydunsky

15. Birthplace

Russia

16 (a) Informant

Sophie Bickman

(b) Address

1815 Baker St.

17 (a)

Burial

(b) Date thereof

Aug

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Mt. Cemetery

Location

German Hill Road

18 (a) Funeral director

Sol Lewinson & Bros.

(b) Address

11 1/2 W. North Ave

AUG 29 1943

Wm. H. North

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *8/28/43* 19 *6:35 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8/26/43* to *8/28/43* 19, and that I last saw him live on *8/28/43* 19.

Immediate cause of death

Cardiac failure

Due to

acute pulmonary edema

Due to

hypertensive C.V.R. disease

Other Conditions

possible myocardial infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Isadore Shorofsky MD*
Address *West Baltimore Hosp* Date signed *8/28/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07653

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5313 Edmonson ave

(c) Hospital or institution: Hood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street 1502 6 42nd St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geo. Trust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17 - 1888

8. AGE: Years 55 Months 5 Days 10
If less than one day hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof Aug 31 - 43
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) registrar

V8 180

AUG 29 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/1943 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1943 to 8-27 1943, and that I last saw her alive on 8-27 1943

Immediate cause of death Cerebral Thrombosis Duration 2 days

Due to Arterio Sclerosis 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James H. Towler

Address Bacon & Deane Date signed 8-28

JAMES G. HOWELL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07654
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

67

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 29 1943

(c) rec'd by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/28

1943

at 9:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1943 to 8/28 1943, and that I last saw him alive on 8/28 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07655

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1605 Gwynns Falls Pkwy

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1605 Gwynns Falls Pkwy
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

TENA HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

ABRAHAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

41

hr.

min.

9. Birthplace

BALTO. MD

(Town, county and state)

10. Usual Occupation

HOUSE WIFE

11. Industry or business

FATHER
MOTHER

12. Name

WOLF HANDEN

13. Birthplace

RUSSIA

14. Maiden Name

IDA HANDEN

15. Birthplace

RUSSIA

16 (a) Informant ABRAHAM HARRIS

(b) Address 1605 Gwynns Falls Pkwy

17 (a) BURIAL (b) Date thereof 8-29-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

HEBREW FRIENDSHIP

Location BALTO. + CONKLIN STS.

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Balto. St

19 (a)

Washington Williams, Jr

AUG 29 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1943 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20-43 to 8-28-43 and that I last saw him alive on 8-28-43.

Immediate cause of death

ACUTE MYOCARDIAL FAILURE

Duration

1 DAY

Due to ACUTE ARTHRITIS RHEUMATIC (?)

2 Mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James T. Laverne MD
Address 1439 E. Balto. St Date signed 8-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07656
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2317 LINDEN AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 LINDEN AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HILDA SHULMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

LOUIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1913

8. AGE: Years Months Days If less than one day
30 0 27 hr. min.

9. Birthplace BALTO. MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

12. Name BENJAMIN PUGATCH

13. Birthplace RUSSIA

14. Maiden Name CELIA PUGATCH

15. Birthplace RUSSIA

16 (a) Informant HUSBAND

(b) Address

17 (a) BURIAL (b) Date thereof 8-29-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MT. CARMEL

Location GERMAN AVE RD

18 (a) Funeral director Jack Jones Inc

(b) Address 1439 E. Balto. St.

19. AUG 29 1943
(Date rec'd by registrar) Henderson Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-43 1943 at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Aug 28 1943 and that I last saw him alive on Aug 28 1943.

Immediate cause of death Carcinoma Intestines

Duration
1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 1943

Major findings of operations: Carcinoma large Intestine

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Milton B. Kuss

Address 2317 Calver Ave Date signed 8/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07657

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Balto. Grail Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

112 N. Pearl St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Nellie Dumber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 2nd 1863

8. AGE: Years

Months

Days

If less than one day

79

11

25

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Dressmaker

11. Industry or business

Schlesinger

12. Name

John T. Dumber

13. Birthplace

Bavaria

14. Maiden Name

Caroline Geis

15. Birthplace

Balto. Md.

16 (a) Informant

Miss Marie Dumber

(b) Address

112 N. Pearl St.

17 (a) Burial

(b) Date thereof

8/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Balto. Md.

18 (a) Funeral director

William Cope, Inc.

(b) Address

127 S. Pearl St.

19. Date of death

(b)

August 30, 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-27

1943, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 1943, to 8-27 1943, and that I last saw her alive on 8-27 1943.

Immediate cause of death

Pneumonia

Due to

Fractured hip and right humerus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Accident

(b) Date of occurrence

8-27-43 at 1:45 PM

(c) Where did injury occur?

Baltimore Md.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Fell on curb (Specify type of place) While at work ho.

(e) Means of injury

Fell on curb

23. Signature

Paul H. Dumber

Address 121 S. Light St.

Date signed 8/27/43

Approved by Thomas J. Maloney, M.D.

G 07658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH930 G 07658
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

O'Sullivan Building

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Alice Walker

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 12, 1869

8. AGE:

Years

Months

Days

If less than one day

73

11

14

hr.

min.

9. Birthplace

Pennsylvania
(Town, county, and state)

10. Usual Occupation

Self

11. Industry or business

At Home

12. Name

William Walker

13. Birthplace

Tipton Pa.

14. Maiden Name

Jane E. Ryble

15. Birthplace

McVeytown Pa.

16 (a) Informant

Alice A. Walker

(b) Address

1508 N. Bond St

17 (a)

Burial

(b) Date thereof

Aug 30, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lundon Park

Location

Balto Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 St. Paul St.

AUG 29 1943

V8 151

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1836 N. Castle Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-26-1943 at 10:40 AM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Howard J. Mulder

M.D.

Date signed

8/26/43

Medical Examiner.

G 07659

BALTIMORE CITY HEALTH DEPARTMENT

G 07659

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1034 W. Fayette St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1034 W. Fayette St
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Tudie Snell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

AA

6 (a) Single, married, widowed, or divorced.

Single (P)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 4, 1885

8. AGE:

Years

Months

Days

If less than one day

58

1

22

hr.

min.

9. Birthplace

Howard Co Md

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

Catherine Snell (P)

15. Birthplace

Howard Co. Md.

16 (a) Informant

Harry Edwards

(b) Address 1034 W. Fayette St

17 (a)

Burial

(b) Date thereof

8/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

18 (a) Funeral director

Katie R. Williams

(b) Address

322 N. Schroeder St.

AUG 29 1943

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1943, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 16, 1943, to August 26, 1943, and that I last saw him alive on August 26, 1943.

Immediate cause of death

Hypertensive Cardiovascular Disease

Due to

Due to Hypertension

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams, M.D.

Address 3021 Madison Co. Date signed 8/23/43

Duration

3 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07660

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ma* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1008 N. Whatcoat St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joan Bastfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female Negro

5. Color or race

6 (a) Single, married, widowed, or divorced *S*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *8-1-43*

8. AGE: Years Months Days If less than one day

28 hr. min.

9. Birthplace *Balto. Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *James S. H. Bastfield*

13. Birthplace *Blackstone Va*

14. Maiden Name *Geraldine E. Clark*

15. Birthplace *Balto. Md.*

16 (a) Informant *Mrs. Geraldine Bastfield*

(b) Address *1008 N. Whatcoat St*

17 (a) *Burial* (b) Date thereof *8-30-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Auburn Cem*
Location

18 (a) Funeral director *Katie R. Williams*

(b) Address *322 N. Schroeder St*

Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 28 1943* at *1:00 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 27 1943* to *Aug 28 1943*, and that I last saw him alive on *Aug 28 1943*.

Immediate cause of death

Malnutrition

Due to *Prematurity*

Due to

Other Conditions *Diarrhea of*

Newborn
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *[Signature]*

Address *Provident Hospital* Date signed *8-28-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

07661 HEALTH DEPARTMENT—CITY OF BALTIMORE 07661

CERTIFICATE OF DEATH ✓138

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 h. Calhoun St. _____ Ward)Length of residence in city or town where death occurred 10 yrs. 10 mos. 19 da. How long in U. S. If of foreign birth? 19 yrs. 10 mos. 19 da.2. FULL NAME Beatrice Hunter(a) Residence: No. 306 h. Calhoun St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U. S. Veteran

specify WAR _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. Color or Race <u>colored</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
6a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____		
6. DATE OF BIRTH (month, day, year) <u>July 7, 1910</u>		
7. AGE <u>33</u>	Years <u>1</u>	Months <u>19</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Domestic</u>		11. Total time (years) spent in this occupation _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		10. Date deceased last worked at this occupation (month and year) _____
12. BIRTHPLACE (city or town) (State or country) <u>Laurens South Carolina</u>		
13. NAME <u>Henry Hunter</u>		
14. BIRTHPLACE (city or town) (State or country) <u>South Carolina</u>		
15. MAIDEN NAME <u>Ora</u>		
16. BIRTHPLACE (city or town) (State or country) <u>South Carolina</u>		
17. INFORMANT (Address) <u>306 h. Calhoun St.</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>W. Auburn Cem.</u> Date <u>8/29, 1943</u>		
19. UNDERTAKER (Address) <u>Katie R. Williams 322 N. Schroeder St.</u>		
20. FILED <u>Washington Williams</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 26, 194322. I HEREBY CERTIFY, That I deceased deceased from 8-18-1943 to 8-26-1943I last saw her alive on 8-25-1943 Death is said to have occurred on the date stated above, at 2:45 p.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary TuberculosisDate of onset 4-26-43

Other contributory causes of importance _____

Was an operation performed? no Date of _____

For what disease or injury? _____

Name of operation physical signs symptomsWhat test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) John S. P. Pampier M. D.(Address) 639 h. Carey St.

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate. OCCUPATION is very important.

U6-29 1943

G 07662

BALTIMORE CITY HEALTH DEPARTMENT

G 07662

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 504 W. Barre Street
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 504 W. Barre St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

MARY LENA BRADLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1898

8. AGE:

Years

Months

Days

If less than one day

45

3

16

hr.

min.

9. Birthplace

D. C.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

? Sanders

13. Birthplace

S. Carolina

14. Maiden Name

?

15. Birthplace

S. Carolina

16 (a) Informant

Rosalie Bradley

(b) Address

504 W. Barre St.

17 (a)

Burial (Burial, cremation, or removal)

8/29/43

(month) (day) (year)

(c) Cemetery or crematory

Olivet - Md.

Location

Olivet - Md.

18 (a) Funeral director

Mrs. Katie P. Williams

(b) Address

322 N. Schuyler St.

19 (a)

(Registrar)

Therese Williams

AUG 29 1943

MEDICAL CERTIFICATION

1:40 P. M

20. DATE OF DEATH August 26, 1943, at

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Tuberculosis, pulmonary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. W. Allen M.D.

Date signed

8-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07663

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1213 Light Street*

(c) Hospital or institution:

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *70 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL, and give town)

(d) Street No. *1912 S. Charles St.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Oscar A. Peters.

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife *Julia Donovan Peters*

Deceased

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 29-1856*

8. AGE:

Years

Months

Days

If less than one day

86

10

27

hr.

min.

9. Birthplace *Fredrick Md*

(Town, county, and state)

10. Usual Occupation *Retired Engineer*

11. Industry or business *B & O. R.R.*

FATHER
MOTHER

12. Name *William D Peters*

13. Birthplace *Md*

14. Maiden Name *Erith Dayhoff*

15. Birthplace *Md*

16 (a) Informant *Mr Howard Peters*

(b) Address *163 E. Randall St*

17 (a) *Burial*

(b) Date thereof *Aug 20 1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Londyn Park*

Location *Bald Md*

18 (a) Funeral director *Garz. Boyer Jr*

(b) Address *512 Hollins St*

UG 29 1943

(b)

d by registrar

Registrar

VS 180

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-26 1943* at *7:25 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-24 1943* to *8-26 1943*, and that I last saw him alive on *8-26 1943*.

Immediate cause of death

Broncho-pneumonia

Duration

1 day

Due to *malnutrition*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Charles B. McDonald*

Address *1213 Light St.* Date signed *8-27-43*

M. D.

G 07664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07664

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1900 Sulgrave Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore City.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1900 Sulgrave Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Harvey Reed Arnold,

3 (b) If veteran, name war
no3 (c) Social Security Account
No. 214-01-6790

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Stella Arnold

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1876

8. AGE:

Years

Months

Days

If less than one day

67

7

21

hr.

min.

9. Birthplace Carroll County, Md.

(Town, county, and state)

10. Usual Occupation

Auditor,

11. Industry or business Liab. Ins. Co.

FATHER
MOTHER

12. Name Elias Arnold,

13. Birthplace Carroll County, Md.

14. Maiden Name Laura Shipley.

15. Birthplace Carroll County, Md.

16 (a) Informant Mrs. Stella Arnold,

(b) Address 1900 Sulgrave Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 8/30/43.

(month) (day) (year)

(c) Cemetery or crematory

Cathedral Cemetery.

Location

Baltimore City.

18 (a) Funeral director L. Vernon Lemmon.

(b) Address 4611 Park Heights Ave.

UG 29 1943

Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1943, at 3.45 P.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1943 to 8/27 1943, and that I last saw him alive on 8/27/ 1943.

Immediate cause of death

Cerebral vascular
accident with right
Due to: sided hemiplegia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none.

Duration

August 13, 1943

PHYSICIAN

Underline the
cause to which
death should be
charged stat-
istically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 5013 Park Heights Ave.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Jackson
G 07665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07665
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *709 Sara Ann St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4*

(e) Length of stay in Baltimore (yrs., mos., or days) *12 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *709 Sara Ann St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Francis Burrell Brundy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Carter

6 (c) If alive, give age *47* years

7. Birth date of deceased (mo., day, yr.)

8-5-1905

8. AGE

Years

Months

Days

If less than one day

35

12

hr.

min.

9. Birthplace

Middlesex

Va

(Town, county, and state)

10. Usual Occupation

Seamstress

11. Industry or business

FATHER
MOTHER

12. Name

James Rich

13. Birthplace

D.C.

14. Maiden Name

Emma Jackson

15. Birthplace

Va

16 (a) Informant

Carly Brundy

(b) Address

709 Sara Ann St

17 (a)

Shipped

(b) Date thereof

8-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

West Point Cem

Location

Middlesex County, Va

18 (a) Funeral director

William A Jackson

(b) Address

916 Penna ave

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/27

19*43* at *6 P M*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *7/15* *1943* to *8/27* *1943*

and that I last saw him alive on *8/27* *1943*

Immediate cause of death *Chronic*

Hypertensive Cardiac

vascular Renal

Due to *Disease*

Due to *Chronic*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Dr Jackson

Address *600 N. Lexington St*

PHYSICIAN

Underline the cause to which death should be charged statistically.

1943

VS 144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07666

Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>216- 2613 Wash Blvd</u> (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days)			2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md</u> (b) County (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>2613 Wash Blvd</u> (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country		
3 (a) FULL NAME <u>Charles W Schwartz, Jr.</u>					
3 (b) If veteran, name war <input checked="" type="checkbox"/>			3 (c) Social Security Account No. <u>217-03-1291</u>		
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>Married</u>			
6 (b) Name of husband or wife <u>Annie E</u>					
6 (c) If alive, give age _____ years					
7. Birth date of deceased (mo., day, yr.) <u>April 3 1888</u>					
8. AGE: Years <u>55</u>	Months <u>4</u>	Days <u>4</u>	If less than one day _____ hr. _____ min.		
9. Birthplace <u>Maryland</u> (Town, county, and state)					
10. Usual Occupation <u>Brass Moulder</u>					
11. Industry or business					
FATHER	12. Name <u>August Schawartz</u>				
	13. Birthplace <u>Germany</u>				
MOTHER	14. Maiden Name <u>Agusta</u>				
	15. Birthplace <u>Germany</u>				
16 (a) Informant <u>Mrs Annie E Schwartz</u>					
(b) Address <u>2613 Wash Blvd</u>					
17 (a) <u>Burial</u> (b) Date thereof <u>8-10-43</u> (Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory <u>Meadow ridge Cem</u>					
Location <u>Wash Blvd</u>					
18 (a) Funeral director <u>Edward Toulson</u>					
(b) Address <u>2559 Wash Blvd</u>					
19 (a) <u>Aug 29 1943</u> (b) <u>to Williams, Md</u> Registrar					

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>August 27, 1943</u> at <u>5 A.M.</u>	
21. I certify that death occurred on the date above stated; that I attended deceased from <u>Jan 1, 1943</u> to <u>August 27, 1943</u> and that I last saw _____ alive on _____ 19____	
Immediate cause of death <u>Acute Heart Block</u>	Duration
Due to <u>Atherosclerosis</u>	
Due to <u>Myocarditis</u>	
Other Conditions <u>lues</u>	
(Include pregnancy within 3 months of death)	
Date of operation _____	
Major findings of operation:	
of autopsy: _____	
22. If death was due to external causes, fill in the following:	
(a) Accident, suicide, or homicide	
(b) Date of occurrence _____ at _____ M	
(c) Where did injury occur? _____ (City or town) (County) (State)	
(d) Did injury occur about home, on farm, industrial place, or public place? _____ While at work? _____ (Specify type of place)	
(e) Means of injury <u>James Jeffay</u>	
23. Signature <u>James Jeffay</u> M. D.	
Address <u>876 Waverly Bank</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07667
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd St.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1701 Linden Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Winton Frederick Hurley Sr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife. Louise Hoffman

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 15, 1880

8. AGE: Years

63

Months

Days

less than one day

hr.

min.

9. Birthplace Salisbury Md.

(Town, county, and state)

10. Usual Occupation Commission Merchant

11. Industry or business not employ for 8 yrs.

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Winton Frederick Hurley Jr.

(b) Address 1701 Linden Ave. Baltimore

17 (a) Burial, cremation, or removal

(b) Date thereof 9/31/53

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 AUG 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1943 11:19 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1943, to 8-27 1943, and that I last saw him alive on 8-27 1943.

Immediate cause of death

Cardio-respiratory failure

Due to

Cachexia

Due to

Probable carcinoma of S-I tract

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John A. Nesbitt, Jr.

Address Union Memorial Hospital

Duration

1 yr 5

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07668
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Lombard & Green & Redwood*

(c) Hospital or institution:

University Hospital 4(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County *Balto.*(c) City or town *Catonsville*
(If outside city or town limits, write RURAL and give town)(d) Street No. *6600 Atamont Ave*
(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Baby Boy Benson Benson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced. *5*

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *8-26-43*8. AGE: Years _____ Months _____ Days *2*
If less than one day
hr. _____ min. _____9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

12. Name *John Benson*13. Birthplace *Willard, Ohio*14. Maiden Name *Marion Whitney*15. Birthplace *Baltimore, Md.*16 (a) Informant *Mother*(b) Address *above*17 (a) *Burial* (b) Date thereof *8/30/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *St. Johns*
Location *East City 7th St.*18 (a) Funeral director *John D. MacHaffey*(b) Address *Catonsville, Md.*19 *AUG 30 1943* *H. H. Williams, Jr.*
(Date for day register) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 28* 19*43*, at *6:50* A. M.21. I certify that death occurred on the date above stated; that I attended
deceased from *8-26-* 19*43*, to *8-28-* 19*43*,
and that I last saw him alive on *8-28* 19*43*.

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work? _____

(Specify type of place)

(e) Means of injury

23. Signature *John Benson*Address *University Hospital*Date signed *8-28-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07669
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Fayette & Calhoun St.*
(c) Hospital or institution: *Franklin Square Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *14*
(e) Length of stay in Baltimore (yrs., mos., or days) *2 years*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Balti*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1506* *Entaw Place*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Refus H. Highsmith

3 (b) If veteran, name war

3 (c) Social Security Account
No. *261-14-5045*

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Thelma Highsmith*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan 7th 1894*

8. AGE: Years *58* Months *7* Days *22* hr. min.

9. Birthplace *Brentley Co. Ga.*
(Town, county, and state)

10. Usual Occupation *Carpenter*

11. Industry or business *to Graham H. Co.*

12. Name *Daniel W. Highsmith*

13. Birthplace *Ga.*

14. Maiden Name *Michelle Morgan*

15. Birthplace *Ga.*

16 (a) Informant *Thelma Highsmith*

(b) Address *1506 Entaw Place*

17 (a) *Buried* (b) Date thereof *9/11/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Myrtha*

Location *Franklin Square*

18 (a) Funeral director *William H. Hume*

William H. Hume

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 29th 1943* *4¹⁰* *P* M

21. I certify that death occurred on the date above stated; that I attended deceased from *19* *Aug 29* *1943*, and that I last saw him alive on *Aug 29* *1943*.

Immediate cause of death *Spontaneous pneumonia*
Franklin

Due to *Esophageal Carcinoma*
of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Aug 15/43*

Major findings of operation *of lower carcinoma of stomach involving liver & pancreas*
of autopsy: *none done*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Calvin Hume*

Address *2356 Entaw Place* Date signed *9/12* M. D.

AUG 30 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07670
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2536 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ROBERT HARRY LITTLE

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. 220-22-2992

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife Rhoda Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1871

8. AGE: Years 71 Months 11 Days 27
If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Prince Produce

12. Name William Little

13. Birthplace Baltimore, Md.

14. Maiden Name Ella Coates

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Chas. Mullineaux

(b) Address 3010 Mosher St.

17 (a) Burial (b) Date thereof 8/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

AUG 30 1943
(Date filed by Registrar)

VS 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1943, at 7:07 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/22 1943 to 8/26 1943
and that I last saw him alive on 8/26 1943

Immediate cause of death Coronary artery disease

Duration
2 yrs

Due to

Due to

Other Conditions Coronary artery disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Benjamin Miller MD

Address 28 30 Wilkens Ave. Date signed 8/27/43

PLEASE WRITE FAINTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07671

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

female

5 Color or race

white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-1943 to 8-29-1943, and that I last saw him alive on 8-29-1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed

AUG 30 1943

Thurston Williams, M.D.

816 W. 14th St.
8/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07672
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3604 Callaway Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

3 (a) FULL NAME

BARNEY BUSATCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

m

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

FATHER
MOTHER

12. Name

Samuel

13. Birthplace

Russia

14. Maiden Name

Ella

15. Birthplace

Russia

16 (a) Informant

Wife

(b) Address

17 (a)

Burial

(b) Date thereof 8-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Windsor Hill Rd

Location

Windsor Hill Rd.

18 (a) Funeral director

John Lyons Inc

(b) Address

1439 E. Pratt St

19 (a)

(b)

Date rec'd by registrar

Registrar

AUG 30 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3604 Callaway Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 29 1943 at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to Aug 29 1943 and that I last saw him alive on Aug 28 1943

Immediate cause of death

Carcinoma of colon

Due to

Carcinoma of liver

Due to

Several carcinomas

Other Conditions

(none)

(Include pregnancy within 6 months of death)

Date of operation

Sept 1942

Major findings of operation: Carcinoma

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

8-29-43 at 7:35 A.M.

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

A. H. Hornstein

Address

733 Avenue

Date signed

8/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07673

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

731 Herring St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

24

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD.

(b) County

(c) City or town

Balti.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

731 Herring St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Max W. Gallett

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-10-6883

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M.

6 (b) Name of husband or wife

Olivia E. Gallett

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Dec 6 1894

8. AGE:

Yrs

Months

Days

48 8 31

hr.

min.

9. Birthplace

Balti.

(Town, county, and state)

10. Usual Occupation

Employee of the

11. Industry or business

Chesapeake Pottery Co.

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Family

(b) Address

731 Herring St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

8/31/43

(c) Cemetery or crematory

Older Hill

Location

Richie Highway

18 (a) Funeral director

Wm. H. Kelly

(b) Address

130 E. Fort Ave.

19

AUG 30 1943

Huntington Halligan, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 27, 1943, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended

deceased from Jan. 5, 1942, to 8-27, 1943.

and that I last saw him alive on 8-27, 1943.

Immediate cause of death

Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

A. J. Gallett

Address

707 E. Fort Ave.

Date signed 8-28-43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 67674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 67674

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2209 Cust Road

(c) Hospital or institution:

at home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

27

(e) Length of stay in Baltimore (yrs., mos., or days)

5 months

3 (a) FULL NAME

Margaret Mullen Murray

3 (b) If veteran, name war

No

3 (c) Social Security Account

No None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Robert Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 5-1867

8. AGE: Years

Months

Days

If less than one day

76

0

23

hr.

min.

9. Birthplace

Fulton, NY

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

none

12. Name

Patrick Mullen

13. Birthplace

Ireland

14. Maiden Name

Mary ?

15. Birthplace

Ireland

16 (a) Informant

Mr. A. B. Keene (day)

(b) Address

2209 Cust Road

17 (a) Burial

(b) Date thereof 8-31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore

18 (a) Funeral director

Stewart Howenlo

(b) Address

108 W. North Ave.

19 (a)

AUG 30 1943

Huntington Williams, M.D.

(Date for burial)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State D.C.

(b) County

Dist of Columbia

(c) City or town

Washington

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3708 Jennifer St. S.W.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 7 1943 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1943 to Aug 28 1943

and that I last saw him alive on Aug 6 1943

Immediate cause of death

Cancer (Carcinoma)

of bladder

Due to

Due to

Other Conditions

(Include previously within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Amuel H. Celow, M.D.

Address

5611 Crutcher St.

Date signed

M. D.

G 07675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07675

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1725 Summit Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1725 Summit Ave

(If rural give location)

(e) Citizen of foreign country?

Greece

(Yes or No)

If yes, name country

3 (a) FULL NAME

Kostas (Charles) Jurnas

3 (b) If veteran, name war

3 (c) Social Security Account

No. 043-05-4558

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

Anastasi Jurnas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1890-Jan-?

8. AGE:

Years

Months

Days

If less than one day

53

54

18

7

hr.

min.

9. Birthplace

Greece

(Town, county, and state)

10. Usual Occupation

Inclom, waiter

11. Industry or business

FATHER

12. Name

George Jurnas

13. Birthplace

Greece

MOTHER

14. Maiden Name

Margaret — ?

15. Birthplace

Greece

16 (a) Informant

Mrs. Eva Davis (daughter)

(b) Address

1725 Summit Ave

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Balto. Md.

18 (a) Funeral director

Sumner 2. Cooney

(b) Address

217 25 St.

19 (a)

(b) Date of death

AUG 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/28

1943. 8:25

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1943 to Aug 28 1943, and that I last saw him alive on Aug 27 1943.

Immediate cause of death

Hypertensive Heart Disease
Coronary Sclerosis

Duration

3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Sgt. Smith

M. D.

Address

1223 E. North Ave

Date signed

8/28/43

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07676
Registered No. 07676

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Madison & Linder
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: DORCHESTER
(c) City or town: Cambridge
(d) Street No.: 313 Oakley St.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country.

3 (a) FULL NAME

John G. Mills
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M 5. Color or race: W 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 21, 1857

8. AGE: Years: 85 Months: 9 Days: 8 If less than one day hr. min.

9. Birthplace: Cambridge, Md.
(Town, county, and state)

10. Usual Occupation: Retired Banker

11. Industry or business: n

12. Name:

13. Birthplace:

14. Maiden Name:

15. Birthplace:

16 (a) Informant: Granville LeCompte

(b) Address: Cambridge, Md.

17 (a) Burial (b) Date thereof: Sept 1, 1943

(c) Cemetery or crematory: Christ Church, Cambridge, Md.

Location: Cambridge, Md.

18 (a) Funeral director: John C. Mitchell

(b) Address: 1900 Eutaw Place

19. Date of death: AUG 30 1943

20. Signature: Huntington Williams, M.D.

21. Address: Md. Gen. Hosp.

22. Date signed: 8/29/43

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/29 1943, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1943 to 8/29 1943, and that I last saw him alive on 8/29 1943.

Immediate cause of death: Myocardial infarction, arterial sclerosis, coronary disease

Due to:

Due to:

Other Conditions: Partial paraplegia, left + cerebral thrombosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury:

23. Signature: G. J. McKinnis

Address: Md. Gen. Hosp.

Date signed: 8/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07677
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ind. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Y.M.C.A. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

- Harry Earl Dorsey
3 (b) If veteran, name war 3 3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced S

- 6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1891

8. AGE: Years 51 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

12. Name James M. Dorsey
13. Birthplace Maryland

14. Maiden Name Fanny Stockdale
15. Birthplace Maryland

- 16 (a) Informant J. Orton Dorsey
(b) Address Owings Mills

- 17 (a) Burial (b) Date thereof Sept. 11, 1943
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Morgan Chapel
Location Woodbridge, Md.

- 18 (a) Funeral director Wm. B. Perryman & Sons
(b) Address Reisterstown, Md.

- AUG 30 1943 (c) Huntington Williams
(City or town) (County) (State)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1943, 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1943 to Aug. 29 1943, and that I last saw him alive on Aug. 28 1943.

- Immediate cause of death Cardiac - respiratory failure

- Due to Cerebral hemorrhage

- Due to Hypertensive cardiac - vascular disease

- Other Conditions

- (Include pregnancy within 3 months of death)

- Date of operation

- Major findings of operations

- of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

- (e) Means of injury

23. Signature George W. Magnuson Jr. M. D.

- Address 332 E. University Place signed 8/24/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07678
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 hrs*(e) Length of stay in Baltimore (yrs., mos., or days) *29 yrs*

3 (a)

William Edward Roman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

*negro*6 (a) Single, married, widowed, or
divorced.*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 19-1913*

8. AGE: Years Months Days If less than one day

30

hr. min.

9. Birthplace *Pandallstown Md*

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name *George Roman*13. Birthplace *Green Springs Valley*

MOTHER

14. Maiden Name *Mattie Harris*15. Birthplace *North Carolina*16 (a) Informant *Mattie Harris Roman*(b) Address *2233 Division St*17 (a) *Burial* (b) Date thereof *Aug 30-1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Mt Auburn*Location *West Port*18 (a) Funeral director *W. Brooks*(b) Address *1463 77. Carey St.*19 (a) *Aug 30 1943* (b) *Attending Physician*

(Date of registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2233 Division St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-23-1943* at *1:10* P.M.21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Sub-arcular hemorrhage, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *8-23-43* at *6:45 A* *14-3* M.(b) Where did injury occur? *North end of 11th Ave.*(c) Did injury occur at home, on farm, industrial place, in public
place? *Public* While at work? *No*(d) Means of injury *Pedestrian, struck by auto.*23. Signature *Howard J. Williams* M.D.

Medical Examiner.

Date signed *8-24-43*

G 07679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07679

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED

(a) State md (b) County BALTIMORE(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 324 Elizabeth Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

PAUL W. HELWIG

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w6 (a) Single, married, widowed, or
divorced.Widowed

6 (b) Name of husband or wife

Berrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 30, 1993

8. AGE:

Years

Months

Days

If less than one day

50628

hr. min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Charles W. Helwig

13. Birthplace

md.

MOTHER

14. Maiden Name

Katherine Rine

15. Birthplace

md.

16 (a) Informant

Mr. Geo. A. Helwig

(b) Address

1720 Selma Ave

17 (a)

Burial

(b) Date thereof

8/30/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Frederick Ave

18 (a) Funeral director

William Marech

(b) Address

715 Light St.

19

AUG 30 1948(b) Huntington Hill, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 9:27 M

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ Accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cellulitis, acutegangrenous to right leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature H. W. Gallun M.D.Date signed 8-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07680

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *South Baltimore Hospital*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *17 hr*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County *ANNE ARUNDEL*
(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *North Lenthall Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F. Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *Aug 27 1943*

8. AGE:

Years

Months

Days

If less than one day

17 hr. min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *Kenneth C Sheppard*

13. Birthplace *D.C.*

MOTHER

14. Maiden Name *Catherine Oram*

15. Birthplace *Balto*

16 (a) Informant *Mr. Kenneth C. Sheppard*

(b) Address *North Lenthall Ave*

17 (a) *Burial*

(b) Date thereof *8/30/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Toussaint Park*

Location *3801 Frederick Ave*

18 (a) Funeral director *William M Marek*

(b) Address *715 Light St*

Aug 30 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 27 1943 at 10:55 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 27 1943* to *Aug 27 1943*, and that I last saw *her* alive on *Aug 27 1943*.

Immediate cause of death *Prematurity*

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Paul H. Lusk*

Address *1212 Light St* Date signed *8/30/43*

G 07681

BALTIMORE CITY HEALTH DEPARTMENT

G 07681

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3015 Mc Elderry St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Joshua T. Gladfelter

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-18-43

8. AGE:

Years

Months

Days

If less than one day

3 3 1/2

16

hr.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Joshua T. Gladfelter

13. Birthplace

Shannon Pt

MOTHER

14. Maiden Name

Irene Barrett

15. Birthplace

Balto

16 (a) Informant

Mrs Joshua T. Gladfelter

(b) Address

3015 Mc Elderry St

17 (a)

Burial

(b) Date thereof

31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location Eastern Ave. near North Pt. Rd

18 (a) Funeral director

William M. Marack

(b) Address

715 Light St

19

JUG EC 1843

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1943, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1943, to 8-29 1943, and that I last saw him alive on 8-28 1943.

Immediate cause of death

Septicemia

Duration

8-23-43

4 days

Due to Staph. aureus

Blood stream infection

8-29-43

Due to

Other Conditions Perforated ulcer entire body.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Louis J. J. Jr.

M. D.

Address

On Seaman St

Date signed

8-29-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07682

07682
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 500 N Belmond Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2

(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 500 N Belmond Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edwin J. Carnes

3 (b) If veteran, name-war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ida Carnes

6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1877

8. AGE: Years Months Days If less than one day

65

8

6

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Balto City

11. Industry or business

Water Dept

FATHER

12. Name

Edwin Carnes

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Ella Pike

15. Birthplace

Baltimore

16 (a) Informant

Mrs Ida Carnes

(b) Address

500 N Belmond Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept 1, 1943

(month) (day) (year)

(c) Cemetery or crematory

Lyndon Park

Location

Rural

18 (a) Funeral director

Wright Funeral Home

(b) Address

2004-8 Orleans St

19 (a) Date of death

Aug 28, 1943

(Date rec'd by registrar)

Thos J. Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1943, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1943, to Aug 28, 1943, and that I last saw him alive on Aug 27, 1943.

Immediate cause of death

Chronic myocarditis

Due to

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. J. Williams, Jr.

Address 2004-8 Orleans St Date signed 8/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07683

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07683

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4307 Springwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Springwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNA LOUISE ROHLFING

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fred. C. Rohlfing
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1886

8. AGE: Years 57 Months 6 Days 22 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Caspar Nies

13. Birthplace Germany

14. Maiden Name Sophie Bauer

15. Birthplace Germany

16 (a) Informant Frederick C. Rohlfing

(b) Address 4307 Springwood Ave.

17 (a) Burial (b) Date thereof 8/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2004-2008 Orleans St.

19 (a) Aug 27 1943 Therapist for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943 12:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10/13 1935 to 8/27 1943 and that I last saw him alive on 8/26 1943.

Immediate cause of death

Myocardial Infarction

Duration
2 yrs.

Due to Acute pericarditis
(Pick's Syndrome)

9 mos.

Due to

Other Conditions Pulmonary Tuberculosis

4 yrs +

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. M. M.

Address 6304 Belair Rd Date signed 8/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07684

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 155 Enon st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give location)

(d) Street No. 155 Enon st
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

m

6 (b) Name of husband or wife Charlie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1890

8. AGE: Years Months Days If less than one day

53

hr.

min.

9. Birthplace Henrico Co. Va.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John James

13. Birthplace Va

14. Maiden Name Jessie Sneed

15. Birthplace Va.

16 (a) Informant Mrs. Marion Johnson

(b) Address 1204 Park Ave

17 (a) Burial (b) Date thereof 8/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory mt. Auburn

Location

18 (a) Funeral director Adolphus H. H. H.

(b) Address 918 S. Broadway

19 (a) Adolphus H. H. H.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/43

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/43 to 8/27/43 and that I last saw him alive on 8/27/43

Immediate cause of death

Cerebral apoplexy
Para gus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Sam R. H. H.

Address 734 W. 18th St.

M. D.

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131 a G 07685
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Kelwood + Green St.*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 1/2*
(e) Length of stay in Baltimore (yrs., mos., or days) *30*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1107 Division St*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Lena Branford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

B

6 (a) Single, married, widowed, or divorced. *M*

6 (b) Name of husband

Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1895

8. AGE:

48

Months

Days

If less than one day

hr.

min.

9. Birthplace

Virginia

(town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

William Whittaker

13. Birthplace

Virginia

14. Maiden Name

Dora Perkins

15. Birthplace

Virginia

16 (a) Informant

Walter Branford

(b) Address

1107 Division St.

17 (a)

Burial

(b) Date thereof

8/30/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Old Point

Location

Virginia

18 (a) Funeral director

John H. Smith

(b) Address

918 E. ...

19 (a)

AUG 26 1943

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1943

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 25 1943* to *Aug 27 1943* and that I last saw her alive on *Aug 27 1943*.

Immediate cause of death

*Acute Congestive Failure
Cardiac Hypertrophy & Dilatation*

Due to

Hypertension

Due to

Chr. Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

Means of injury

23. Signature

Ralph J. Chavira

Address

Univ. Hosp.

Date signed

8/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07686

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **2241 EASTERN AVE.**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **LIFE**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County **BALTO.**

(c) City or town **BALTIMORE**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **2241 EASTERN AVE.**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JEANETTE ALBERS

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. **NONE**

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife **GEORGE ALBERS**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **SEPT. 9 1903**

8. AGE: Years Months Days If less than one day

39

11

19

hr.

min.

9. Birthplace **BALTIMORE MD.**

(Town, county, and state)

10. Usual Occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **FREDERICH KOEHLER**

13. Birthplace **BALTO. MD.**

14. Maiden Name **LOUISE VOELKER**

15. Birthplace **BALTO. MD.**

16 (a) Informant **GEORGE ALBERS (HUSBAND)**

(b) Address **2241 EASTERN AVE.**

17 (a) **BURIAL** (b) Date thereof **AUG. 30/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **ST. PAULS**

Location **S. PONCA ST.**

18 (a) Funeral director **Lilly and Geiler Inc.**

(b) Address **403 S. WOLFE ST.**

19 (a) **AUG 30 1943** **Huntington Williams**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **AUG. 26 1943, at 4 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **8-23 1943** to **8-26 1943**, and that I last saw her alive on **8-25 1943**.

Immediate cause of death

Advanced Pulmonary T. on Central Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature **W. J. J. Eastern Ave**

Address **W. J. J. Eastern Ave** Date signed **8/27/43**

Duration

5 MO.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

299705

G 07687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07687

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **LIFE**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **305 Macon St.**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Joseph Wright

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. **NONE**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife **ANNA WRIGHT**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **JULY 2 1886**

8. AGE:

Years

Months

Days

If less than one day

57

1

26

hr.

min.

9. Birthplace **BALTIMORE MD.**

(Town, county, and state)

10. Usual Occupation **LAUNDRYMAN**

11. Industry or business

FATHER
MOTHER

12. Name **Howard Wright**

13. Birthplace

MD.

14. Maiden Name **CARRIE HARRON**

15. Birthplace

Md.

16 (a) Informant

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) **BURIAL**

(Burial, cremation, or removal)

(b) Date thereof

SEPT. 1/43

(c) Cemetery or crematory **LOUDON PARK**

Location **FREDERICK AVE.**

18 (a) Funeral director **Lilly and Quiler, Inc.**

(b) Address

403 S. WOLFE ST.

19 (a) **AUG 30 1943**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-28

19 **43** at **11:45 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **8-17 1943** to **8-28 1943**, and that I last saw him alive on **8-28 1943**.

Immediate cause of death **Cardiac failure & early uremia**

Due to **Hypertensive Cardio-vascular disease**

Due to

Other Conditions **Carcinoma Rectum**

(Include pregnancy within 3 months of death)

Date of operation **8-24-43**

Major findings of operation: **Carcinoma**

of Rectum

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

John H. Mehne

Address **Johns Hopkins Hosp.**

Date signed

8-28-43

Duration **2 1/2 hrs**

8 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07688

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 877 W. Fayette Street
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

BARBAR L JACK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1943

8. AGE: Years Months Days If less than one day
3 16 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

12. Name Lawrence BARBAR

13. Birthplace London, TENN.

14. Maiden Name Ann Fowler

15. Birthplace Stokes, N.C.

16 (a) Informant hospital records

(b) Address

17 (a) Burial (b) Date thereof 8.29.43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Ave.

18 (a) Funeral director Robert Brooks & Son

(b) Address 1338 Hollins Street.

19 (a) AUG 30 1943
(Date)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1943 at 12:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1943 to Aug 28 1943, and that I last saw him alive on Aug 28 1943.

Immediate cause of death

respiratory failure

Duration

Due to Dehydration

? 1 week

Due to Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith

Address Sydenham Hosp. Date signed 8-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07689

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland 0260
(b) Street address PROVIDENT HOSPITAL
(c) Hospital or institution: 1514 DIVISION ST.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give location)
(d) Street No. 433 CUMMINGS ST. 87
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EMMA EDWARDS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

COL.

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

RODERICK

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

2-2-1911.

8. AGE: Years

32

Months

56

Days

26

If less than one day

hr.

min.

9. Birthplace

BALTIMORE Md.

(Town, county, and state)

10. Usual Occupation

HOUSE WORK

11. Industry or business

12. Name

RUFUS BRADFORD

13. Birthplace

Md.

14. Maiden Name

FRANCIS MURDOCK

15. Birthplace

Md.

16 (a) Informant

RODERICK EDWARDS.

(b) Address

433 CUMMINGS ST.

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal)

8-31-43

(c) Cemetery or crematory

WATERBURY CEM.

Location

ANNA ARUNDEL COUNTY

18 (a) Funeral director

William A. Jackson

(b) Address

916 Penn Ave

AUG 30 1943

William A. Jackson

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1943 11:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26-1943 to 8-28-1943 and that I last saw her alive on 8-28-1943

Immediate cause of death

Peritonitis

Due to Ruptured tubercular abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. E. Wilson M. D.
Address 803 Fremont Ave Date signed 8-29-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07690

JL - 83484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07690

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **6 hrs.**
(e) Length of stay in Baltimore (yrs., mos., or days) **38 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **613 S. Bond St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Alexander Surarowski, or Alexander Sezurovski

3 (b) If veteran, name war

3 (c) Social Security Account

No. **218-14-9750**

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1904 3-15-85

8. AGE: Years Months Days

If less than one day

58 **5** **12** hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Farm Hand

11. Industry or business

12. Name

Alexander

13. Birthplace

Poland

14. Maiden Name

?

15. Birthplace

Poland

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

Buried **8-21-43**

(c) Cemetery or crematory

Location **Balto. Md.**

18 (a) Funeral director

(b) Address **2435 E. Oliver St.**

Aug 30 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/27/43 19 **at 4:30 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **8/24** 19**43**, to **8/27** 19**43**, and that I last saw him alive on **8/27** 19**43**

Immediate cause of death

Lobar pneumonia

Duration

2 d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **E. L. Sargman**

Address **B. C. H.** Date signed **8/28**

PHYSICIAN

Underline the cause to which death should be charged statistically.

affirms to Howard J. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07691
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

negro

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Lawrence Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4-18-1902

8. AGE: Years

41

Months

4

Days

9

If less than one day

hr.

min.

9. Birthplace

New Windsor - Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Curtis Bay

12. Name

Theodore Dorsey

13. Birthplace

New Windsor, Md

14. Maiden Name

Margaret Dorsey

15. Birthplace

New Windsor - Md.

16 (a) Informant

Lawrence Dorsey

(b) Address

518 N. Delaware St

17 (a) Burial

Funeral

(b) Date thereof Aug. 31, 1943

(c) Cemetery or crematory

Arbutus Memorial

Location

18 (a) Funeral director

Mrs. Kate P. Williams

(b) Address

322 N. Delaware St.

19 (a) Signature

Dr. William H. Williams

20 (a) Signature

Dr. William H. Williams

21 (a) Signature

Dr. William H. Williams

22 (a) Signature

Dr. William H. Williams

23 (a) Signature

Dr. William H. Williams

24 (a) Signature

Dr. William H. Williams

25 (a) Signature

Dr. William H. Williams

26 (a) Signature

Dr. William H. Williams

27 (a) Signature

Dr. William H. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

518 N. Delaware St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1943 to Aug 27 1943 and that I last saw her alive on Aug 22 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

Due to

Due to

Other Conditions Aortic Valvulitis

Right Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Dr. William H. Williams

Address Providence Hospital

Date signed Aug 27 1943

M. D.

AUG 30 1943

VS 154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

437838 07692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07692

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1008 E. Lexington

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Henry Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

separated

6 (b) Name of husband or wife

Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1873

8. AGE: Years

Months

Days

If less than one day

70

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

?

?

13. Birthplace

?

?

MOTHER

14. Maiden Name

Jennie Jones

15. Birthplace

?

?

16 (a) Informant

Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Aug 31, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cemetery

Location

9.6. County Md.

18 (a) Funeral director

Rev. Robert G. Clark, Jr.

(b) Address

1129 N. Caroline St

19 (a)

(b)

William Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1943, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1943, to Aug. 28, 1943, and that I last saw him alive on Aug. 28, 1943.

Immediate cause of death

Respiratory Failure

Due to

Arteriosclerotic Heart Disease

Due to

Other Conditions

Coronary Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Abraham G. Gonsky

Address

Johns Hopkins Hospital

Date signed

8-28-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

AUG 30 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SM G 07693
82372

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07693
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. 1 mo. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Brunt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

William Batty

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

Male

Colored

Separated

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1871

8. AGE: Years

Months

Days

If less than one day

72

2

21

hr.

min.

9. Birthplace Masa.

(Town, county, and state)

10. Usual Occupation None - relief

11. Industry or business

FATHER

12. Name Edward Batty

13. Birthplace Md.

MOTHER

14. Maiden Name Emily Hall

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) Burial (b) Date thereof Aug 31 / 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory T. T. Calvary Cemetery
Location A. G. County, Md.

18 (a) Funeral director Robert A. Elliott, Dgt

(b) Address 1129 N. Charles St.
Thurgood Marshall, Md.

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1943 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1943 to 8-27 1943, and that I last saw him alive on 8-27 1943.

Immediate cause of death

Cerebral Thrombosis
Uremia
Benign Prostatic Hypertrophy

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation 7-29-43

Major findings of operations Benign Prostatic Hypertrophy
of autopsy.

Duration

1 mo.
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald R. Webb
Address Baltimore City, Md. Date signed 8-28-43

AUG 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07694

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07694

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 905 S Sharp St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3. (a) FULL NAME

Bernard Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Balt.

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

12. Name

Daniel Stewart

13. Birthplace

Baltimore Md

14. Maiden Name

Josephine Elliott

15. Birthplace

M.C.

16 (a) Informant

Josephine Stewart

(b) Address

905 S Sharp St

17 (a) Burial

(b) Date thereof Aug 31 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

A.A. Co Md

18 (a) Funeral director

Burial & Cremation

(b) Address

108 W Montg Dr

19 (a)

(b)

by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/29 1943 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1943 to 8/29 1943 and that I last saw him alive on 8/28 1943.

Immediate cause of death

Respiratory failure

Due to

Nutritional diarrhea

Due to

primarily the

dehydration

malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Renshaw

Address

Univ. Hosp.

Date signed

M.D.

8/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G 07695

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 930 S Sharp Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Bennett

3 (b) If veteran, name war

3 (c) Social Security Account

No. 48-01-5127

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 19

8. AGE: Years

26

Months

2

Days

10

If less than one day

hr.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual Occupation

Lab

11. Industry or business

FATHER

12. Name

James Bennett

13. Birthplace

S.C.

MOTHER

14. Maiden Name

Elizabeth Brown

15. Birthplace

S.C.

16 (a) Informant

Elizabeth Gray

(b) Address

930 S Sharp Street

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Aug 9/2/43

(c) Cemetery or crematory

Mt Calvary

Location

A.A. Co. Md

18 (a) Funeral director

David Brown Jan

(b) Address

108 W Montgomery St

19 (a)

(Date)

VS

AUG 30 1943

Thaddeus Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/29/43 5 W M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8/43 to 8/29/43, and that I last saw him alive on 8/25/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

122 W Lee

Date signed

8/30/43

G 07696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *94W*

G 07696

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 105 Rochester Place

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

HARRY B. SCHEVE

3 (b) If veteran, name war
Yes World War I3 (c) Social Security Account
No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Marie Gruebl Scheve

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1898

8. AGE:

Years

Months

Days

If less than one day

45

6

27

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Deputy Chief

11. Industry or business

Fire Department

FATHER

12. Name Frank B. Scheve

13. Birthplace Baltimore

MOTHER

14. Maiden Name Anna L. Heim

15. Birthplace Germany

16 (a) Informant Mrs. Marie M. Scheve

(b) Address 105 Rochester Place

17 (a) Burial

(b) Date thereof 8/31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director

Chas. J. Evans, Inc.
118 N. Mt. Royal Ave.
Baltimore, Md.

19 (a) (Date rec'd by registrar)

(b) *Huntington Williams, M.D.*
Registrar

MEDICAL CERTIFICATION

7 A.

20. DATE OF DEATH August 27, 1943, at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury

23. Signature *H. J. Williams* M.D.

Date signed 8-27-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07697

MULLEN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07697

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1132 N. Carey Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 4 7/8

3 (a) FULL NAME

Jennie Mullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female colored

5. Color or race

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Richard Mullen

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 1, 1878

8. AGE:

Years

Months

Days

If less than one day

65

3

29

hr.

min.

9. Birthplace Accomac Co., Virginia
(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

FATHER

12. Name Appie Mapp

13. Birthplace Accomac Co., Virginia

MOTHER

14. Maiden Name Mary (?)

15. Birthplace Accomac Co., Virginia

16 (a) Informant Mrs. Viola Sample (daughter)

(b) Address 1132 N. Carey Street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9-2-43
(month) (day) (year)

(c) Cemetery or crematory

St. Calvary

Location

Baltimore, Md.

18 (a) Funeral director George Nelson

(b) Address 1303 Proctor St.

19 AUG 30 1943 Huntington Williams, M.D.

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1132 N. Carey Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943 at 6⁰⁰ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 11, 1942 to 8/30 1942 and that I last saw her alive on 8/29 1942.

Immediate cause of death

Cerebral Hemorrhage

Duration

6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Carson E. Johnson

Address 1802 Penna Ave

Date signed 8/30/43

G 07698

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07698
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.

(b) Street address

(c) Hospital or institution:

Provident Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.e.s.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2424 Madison Avenue

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

JOSEPH JONES Mackey

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 25, 1908

8. AGE: Years

35 38

Months

5

Days

3

If less than one day

hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

FATHER
MOTHER

12. Name

Joseph P. Jones

13. Birthplace

Md.

14. Maiden Name

Isabella J. Jones

15. Birthplace

Md.

16 (a) Informant

Isabella Mackey (Mother)

(b) Address

2424 Madison Ave

17 (a)

Burial

(b) Date thereof

9-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

Baltimore, Md.

18 (a) Funeral director

George E. Kelley

(b) Address

1303 Princeton St.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1943 at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an
Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Traumatic amputation of the right leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 8-28-43 at 12:05 A. 13-3 M.

(b) Where did injury occur? 2224 Madison Avenue.

(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? No

(d) Means of injury Struck by #16 Streetcar.

23. Signature Howard J. Luciani M.D.

Date signed 8-30-43 Medical Examiner.

1943

AUG 30 1943

VR 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07699
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1370 Strickland St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

Black

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 2, 1943

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

James Lake

13. Birthplace

Baltimore

14. Maiden Name

Christine Hopkins

15. Birthplace

Baltimore Md

16 (a) Informant

(b) Address

1370 Strickland St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

9-1-43

(c) Cemetery or crematory

Location

Arbutus Men. Park

Baltimore Co. Md

18 (a) Funeral director

(b) Address

George Nelson

1313 Crescent St

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/28 1943, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1943, to 8/28 1943, and that I last saw h&r alive on 8/28 1943.

Immediate cause of death Respiratory failure

Due to nutritional diabetes

Dehydration

Due to possible sclerema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Josephine E. Renshaw

Address

Unit Hospital

Date signed

8/28/43

AUG 30 1943

G 07700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07700
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Baltimore, Maryland**
(c) Hospital or institution:
St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **City**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1321 E. North Avenue**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM T. JOYNES

3 (b) If veteran, name war
None3 (c) Social Security Account
No. **Railroad**4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. **Married**6 (b) Name of husband or wife **Fannie Joynes.**6 (c) If alive, give age **25** years7. Birth date of deceased (mo., day, yr.) **June 15, 1913**8. AGE: Years **30** Months **2** Days **14** If less than one day
min.9. Birthplace **Virginia**

(Town, county, and state)

10. Usual Occupation **Penna. Railroad Brakeman.**11. Industry or business **Penna. R.R.**12. Name **Henry T. Joynes**13. Birthplace **Virginia**14. Maiden Name **Ida Doughty**15. Birthplace **Virginia**16 (a) Informant **Fannie Joynes.**(b) Address **1321 E. North Avenue**17 (a) **Burial** (b) Date thereof **Sept. 2, 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Tasley Cemetery**Location **Tasley Virginia**18 (a) Funeral director **George J. Ruth, Inc.**(b) Address **1735 Harbor Avenue**19 (a) **Harold J. Williams** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 29** 19 **43** at **2:20** P.M.

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to **his** death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Shock

Due to **Traumatic amputation left thigh**
Comp. comminuted fracture - right leg
Other Conditions **Fractured ribs**
Pneumothorax
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury **8/29/43** at **10-1** **5 A** M.(b) Where did injury occur? **Ball's Pt. Yard Penna. R.R.**(c) Did injury occur at home, on farm, industrial place, in public
place? **Public** While at work? **Yes**(d) Means of injury **Fell between moving r.r. cars**23. Signature **Harold J. Williams** M.D.Date signed **8/30/43** Medical Examiner.

Physicians: please write the cause of death clearly and legibly.

AUG 30 1943

G 07701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07701

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

13 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Martha Geraldine Severson

3 (b) If veteran, name war

3 (c) Social Security Account

No.

Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Dec. 13 - 1941

8. AGE:

Years

Months

Days

If less than one day

1 20

hr.

min.

9. Birthplace

Baltimore, Ind.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Thomas Severson

FATHER

13. Birthplace

Ind.

MOTHER

14. Maiden Name

Benidicta Severson

15. Birthplace

Ind.

16 (a) Informant

Thos. Severson

(b) Address

3023 O'Donnell St.

17 (a)

Burial

(b) Date thereof

8/31/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Our Lady of Mercy

Location

Old Frederick Rd. N. E.

18 (a) Funeral director

(b) Address

3000 E. Baltimore St.

19 (a)

Date of registration

August 30, 1943

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind.

(b) County

(c) City or town

Baltimore

(d) Street No.

3023 O'Donnell St.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 29, 1943, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16, 1943, to Aug. 29, 1943, and that I last saw her alive on Aug. 29, 1943.

Immediate cause of death

Placenta of Infancy

Due to

Due to

Other Conditions

Malnutrition

Congenital Heart Disease

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

William H. Luntz

Address

St. Joseph's Hospital

Date signed

8/31/43

G 07702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07702

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Funeral

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

AUG 30 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED

(a) State

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1943, at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943, to Aug 30 1943, and that I last saw him alive on Aug 25.

Immediate cause of death

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address University Hosp

Date signed 8/30

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07703

Registered No.

1. PLACE OF DEATH: BALTIMORE CITY.
 (a) Baltimore City, Maryland
 (b) Street address 1311 NORTH MONROE STREET
 (c) Hospital or institution: NONE
 (d) Length of stay in hospital or inst. (yrs., mos., or days) X
 (e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
 (a) State MARYLAND (b) County
 (c) City or town BALTIMORE CITY.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No 1311 NORTH MONROE STREET
 (If rural give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country

3 (a) FULL NAME LAFAYETTE JOHNSON.

3 (b) If veteran, name war

3 (c) Social Security Account
No. 217-03-1246.

4. Sex M. 5. Color or race Col 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-1899

8. AGE: Years Months Days If less than one day
 44 11 24 hr. min.

9. Birthplace Bluefield W. Va.
 (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden Name unknown

15. Birthplace

16 (a) Informant Sophia Jackson

(b) Address

17 (a) Burial (b) Date thereof 9-1-43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
 Location A. A. County Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna Ave

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 29 1943 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 15 43 to AUG 29 1943, and that I last saw him alive on AUG 29 1943.

Immediate cause of death

Duration

CHRONIC MYOCARDITIS AUG 15 1943

Due to ARTERIOR SCLEROSIS 1943

Due to CHRONIC INTERSTITIAL

NEPHRITIS 1943

Other Conditions

(Include pregnancy within months of death)

Date of operation NONE

Major findings of operations NONE

of autopsy NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. A. Cloutier

Address 3013 ST PAUL STREET Date signed 8/29/43

AUG 30 1943 Registrar

G 07704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07704

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

DoA West Baltimore Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3800 Towanda Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Benjamin Mael

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years Months Days If less than one day
60 hr. min.9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cattle Dealer

12. Name Hirsch Mael

13. Birthplace Russia

14. Maiden Name Sarah ?

15. Birthplace Russia

16 (a) Informant Mrs Lillian Mael

(b) Address 3800 Towanda Ave

17 (a) Burial (b) Date thereof August 31, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 Hamilton Ave

AUG 30 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/29/43 11.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George B. McCallum, M.D.

Date signed 8/30/43

Medical Examiner.

07705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

169

Registered No.

G 07705

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mr. Hope Retreat

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. +

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.Y.

(b) County King

(c) City or town Brooklyn

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Rev. Father Victor Kozlowski

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

no

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1, 1896

8. AGE: Years Months Days If less than one day

47

3

29

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Priest

11. Industry or business

FATHER

12. Name

Poland

13. Birthplace

Poland

14. Maiden Name

Poland

15. Birthplace

16 (a) Informant Mr. Hope Retreat

(b) Address 6420 Rockton Rd

17 (a)

Burial

(b) Date thereof

Aug. 31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Calvary Cemetery

Location

Brooklyn, N.Y.

18 (a) Funeral director

St. Vincent Monks

(b) Address

108 W. North Ave.

19 AUG 31 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1943, at 9 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Mutilated Head & body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/30/43 at 8:30 A.M.

(b) Where did injury occur? Patton Ave. Mr. Hope Retreat

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Struck by N. M. R. R. train

23. Signature Howard J. Walsci M.D.

Date signed 8/30/43

Medical Examiner.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07706
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Martin Cosgrove

82997

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife

Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1881

8. AGE: Years Months Days If less than one day
61 10 28 hr. min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Thoms

13. Birthplace Md.

14. Maiden Name Virginia Wilson

15. Birthplace Md.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/31/43
(Burial, cremation, or other)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.

(b) Address

1217 St. Paul St.

19 AUG 31, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1943 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Aug. 2 1943 to Aug. 24 1943
and that I last saw him alive on Aug. 24 1943

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Hattner

Address R.C.N. Date signed 8/25/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07707

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3822 Kimble Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3822 Kimble Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Cecilia Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Charles Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 21st 1890

8. AGE:

Years

Months

Days

If less than one day

53

0

9

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At home

FATHER

12. Name

James P. Byrnes

13. Birthplace

Balto Md.

MOTHER

14. Maiden Name

Mary E. Snicknell

15. Birthplace

Lower Marlboro Md.

16 (a) Informant

Wm D. Livingston

(b) Address

3822 Kimble Rd

17 (a)

Burial

(b) Date thereof

9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Worland Park

Location

Parkville Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

AUG 31 1943

(Date rec'd by registrar)

Livingston Williams M.D.

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 30th 1943 5:29 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Aug 30 1943, and that I last saw him alive on Aug 30 1943.

Immediate cause of death

Chronic myocarditis

Due to

Rheumatic fever

Due to

Other Conditions

Pancarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

N. V. Harbold

M.D.

Address 4206 Harford Road

Date signed 8/30/43

Duration

15 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

07708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07708
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *University Hospital*

(c) Hospital or institution:

Green & Lombard St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)(d) Street No. *1416 Lenox St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

AMANDA UOSEPH

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-8-1943

8. AGE:

Years

Months

Days

If less than one day

*3**20*

hr.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Wm Joseph

13. Birthplace

Pai

14. Maiden Name

Evelyn Tracton

15. Birthplace

Md

16 (a) Informant

Wm Joseph

(b) Address

*1416 Lenox St*17 (a) *Burial*(b) Date thereof *8-31-43*
(month) (day) (year)

(c) Cemetery or cremation

St. Auburn Cms

Location

Baltimore Md

18 (a) Funeral director

William A. Fisher

(b) Address

916 Pennsylvania

AUG 31 1943

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-28* 19*43* at *9:25* P M21. I certify that death occurred on the date above stated; that I attended deceased from *8-27* 19*43* to *8-28* 19*43*, and that I last saw her alive on *8-28* 19*43*.Immediate cause of death *Unknown*

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *P. A. Longway, Jr.* M. D.Address *Univ. Hospital* Date signed *8-28-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

09

BALTIMORE CITY HEALTH DEPARTMENT

G 07709

JL - 82748

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) ~~State~~ Maryland County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 718 S. Bond St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Sarah Frances Hardee -or- Jackson -or- Kesterton

3 (b) If veteran, name war

3 (c) Social Security Account No. 2

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Milton Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1906

8. AGE: Years 37 Months 2 Days 6 If less than one day hr. min.

9. Birthplace Miss

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name James Adams

13. Birthplace Miss

14. Maiden Name Louise McGraw

15. Birthplace Ky

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 30 1943

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 21 1943 at 1st St. William M. P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1943 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1943, to 8/14 1943, and that I last saw her alive on 8/14 1943.

Immediate cause of death.

Thrombosis

Due to Chron. glom. nephritis

Due to

Other Conditions Prob. portal cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Surman

Address B C H

Date signed 8/14

PHYSICIAN

Underline the cause to which death should be charged statistically.

Possible cause of death should be clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07710
Registered No.

JL - 83215

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 718 S. Charles St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Willie Miles

3 (b) If veteran, name war

3 (c) Social Security Account
No. 2

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1883

8. AGE:

Years

Months

Days

If less than one day

60

5

13

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

Wesley Miles

13. Birthplace

Md.

14. Maiden Name

Fannie King

15. Birthplace

Md.

16 (a) Informant B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 30 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

AUG 31 1943
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-18 1943 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8:15 1943 to 8:18 1943 and that I last saw him alive on 8-18 1943.

Immediate cause of death

Carcinoma of Esophagus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Donald B. Jeff

Address

Baltimore Hosp

Date signed 8-24-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07711
Registered No.

AB-82560

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **4940 Eastern Ave.**

(c) Hospital or institution:

Baltimore City Hospitals(d) Length of stay in hospital or inst. (yrs., mos., or days) **12 days**(e) Length of stay in Baltimore (yrs., mos., or days) **39 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **No Home** (If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Kellum

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
C6 (a) Single, married, widowed, or
divorced. **Widowed**6 (b) Name of husband or wife **Mary (D)**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan. 7-1888**8. AGE: Years **75** Months **7** Days **18**
If less than one day hr. min.9. Birthplace **Va.**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Edwin Kellum**13. Birthplace **Va.**14. Maiden Name **Harriet Meirs**15. Birthplace **Va.**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records**17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location **UNIVERSITY MEDICAL SCHOOL AUG 30 1943**18 (a) Funeral director **Commissioner of Health**

(b) Address

19 **AUG 31 1943** **Huntington Williams M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **8/24 1943 at 5:10 P.M.**21. I certify that death occurred on the date above stated; that I attended
deceased from **7/12 1943 to 8/24 1943**
and that I last saw him alive on **8/27 1943**Immediate cause of death **Cerebral
vascular accident**Due to **Hypertensive C.V.
disease**

Due to

Other Conditions **Epididymitis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **E. L. Sargman M.D.**Address **BCH** Date signed **8/26**Duration
4 d.**?****?****?**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

79593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07712
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mo., or days) 6 mo. 18 days

(e) Length of stay in Baltimore (yrs., mo., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 129 Charles St.

(e) Citizen of foreign country? No Naturalized Citizen
If yes, name country. Of United States of America

3 (a) FULL NAME

Theophilis King

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1893

8. AGE: Years Months Days If less than one day

49

11

19

hr.

min.

9. Birthplace West Indies

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Thomas King

13. Birthplace West Indies

14. Maiden Name Eva Liner Artery

15. Birthplace West Indies

16 (a) Informant Baltimore City Hospitals

(b) Address (Records)

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 30 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 31 1943
(Date rec'd by registrar) *Thurston Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.20 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1942 to 8-20 1943, and that I last saw him alive on 8-21 1943.

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Donald M. Webb*

Address *Baltimore City Hosp* Date signed *8.24.43*

Duration

1 yr +

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46e

G 07713
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Martha Dennis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-23-99

8. AGE:

Years 64

Months 5

Days 5

If less than one day

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Regi Williams

13. Birthplace

Md

14. Maiden Name

Hannah Johnson

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof

9-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cem

Location

A.A. Co., Md

18 (a) Funeral director

Mr. Francis A. Herndon

(b) Address

578 W. Biddle St.

AUG 31 1943

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2456 Brewsterwood

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 28 1943 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1943 to Aug 28 1943 and that I last saw him alive on Aug 28 1943.

Immediate cause of death

Hemorrhage

& Cerebral aneurysm

Duration

Due to

Cancer of Colon & Resection.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8-27-43

Major findings of operations

Ca colon

& Node involvement.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John W. Chambers

Address

John W. Chambers

Date signed

9/2/43

G 07714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07714

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3700 N. Charles St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3700 N. Charles St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Owens.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18978. AGE: Years 30 Months 5 Days 11 hr. min.9. Birthplace Howard Co. Md.

(Town, county, and state)

10. Usual Occupation book

11. Industry or business

12. Name

Not known

13. Birthplace

14. Maiden Name

Not known

15. Birthplace

16 (a) Informant Floyd G. Owens(b) Address 333 Dolphin St17 (a) Burial (b) Date thereof 9-1-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Delcrest Mem. ParkLocation Balta Co. Md.18 (a) Funeral director Mrs. Frances A. Hemlock(b) Address 575 W. Biddle St19 (a) AUG 31 1943 Huntington Williams Registrar

(Date of registration) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1943 at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis.

Due to

Other Conditions Scrotal Hernia.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature Hugh B. McNeely M.D.

Medical Examiner.

8/28/43

G 07715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07715

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2927 Druid Hill Ave(e) Citizen of foreign country 2037 (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS

JACKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

col

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

54

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Not known

13. Birthplace

14. Maiden Name Not known

15. Birthplace

16 (a) Informant Fannie Johnson

(b) Address 2077 Dey Rd, Suite A1.

17 (a) Burial (b) Date thereof 9-1-43
(Burial, cremation, or reburial) (month) (day) (year)(c) Cemetery or crematory Mt. Calvary
Location A.A. Co., Md.

18 (a) Funeral director Mrs. Thelma A. Hemmley

(b) Address 578 W. Biddle St.

19 (a) AUG 31 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1943, at 30. M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. J. Wallenreber M.D.

Medical Examiner.

Date signed 8-29-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

468 G 07716
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 806 Cator Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Cator Ave.,
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME Joseph Edward McCarthy.

3 (b) If veteran, name war
no

3 (c) Social Security Account
No. 717-07-7494

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1888

8. AGE: Years 54 Months 9 Days 4
hr. min.

9. Birthplace Baltimore, City.
(Town, county, and state)

10. Usual Occupation Baggage Room

11. Industry or business Penna. R.R. Station.

12. Name Patrick McCarthy.

13. Birthplace Ireland.

14. Maiden Name Cecelia Conway,

15. Birthplace Ireland.

16 (a) Informant Miss M. Gertrude McCarthy,

(b) Address 806 Cator Ave.

17 (a) Burial (b) Date thereof 8/31/43,
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral,
Location Baltimore City.

18 (a) Funeral director B. Vernon Lemmon

(b) Address 4611 Park Heights Ave.

19 (a) AUG 31 1943 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1943, at 2 A. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from June 15, 1943, to 8/28 1943
and that I last saw him alive on 8/28 1943.

Immediate cause of death

Carcinoma of liver

Due to Generalized

Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

Duration

6 mos.

6 mos.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Frank N. Ogden

Address 2701 N. Calvert St. Signed 8/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07717

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive and 31st St.,

(c) Hospital or institution:

US Marine Hospital, Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1209 West Lombard Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES MILLARD COX

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. 215 - 12 - 2884

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife NONE

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) March 24, 1898

8. AGE: Years

45

Months

5

Days

4

If less than one day

hr.

min.

9. Birthplace MARTINSBURG, WEST VIRGINIA

(Town, county, and state)

10. Usual Occupation SHIP JOINER

11. Industry or business MARYLAND DRYDOCK

FATHER
MOTHER

12. Name CHARLES HAMILTON COX

13. Birthplace LEXINGTON, VA.

14. Maiden Name ALICE MEADOWS

15. Birthplace LEXINGTON, VA.

16 (a) Informant Records-US Marine Hospital,

(b) Address Baltimore, Maryland.

17 (a) Burial (b) Date thereof 8/31/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto., Md.

19 (a) Date of death 8/28/43 (b) Signature of Registrar

VB 150

Va-13566

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1943, at 1:25 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13, 1943, to Aug. 28, 1943, and that I last saw him alive on Aug. 28, 1943.

Immediate cause of death Hemorrhage from esophageal

varices

Due to Cirrhosis of the liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy As above

Duration

Several days

Several years apparently.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address Surgeon, US PHS,

Date signed 8/28/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07718

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1520 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WALTER G. HAMMOND

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. no

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ada Va
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1878

8. AGE: Years Months Days If less than one day
65 1 19 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Builder

11. Industry or business Own business

12. Name John M. Hammond

13. Birthplace Md.

14. Maiden Name Sophie Stockman

15. Birthplace Md.

16 (a) Informant Mrs. Ada V. Hammond

(b) Address

17 (a) Burial (b) Date thereof 9/1/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 AUG 31 1943

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1943 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7:15 - 1943, to 8:29 1943, and that I last saw him alive on 8-25 1943.

Immediate cause of death
Atherosclerosis of coronary arteries

Due to

Due to

Other Condition Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of injury)
(e) Means of injury

23. Signature J. T. Williams
Address 1901 Euters Date signed 9/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07719

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belwood & Kenna Sts.

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Hours

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3214 Spring Falls Place
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Richard Edward Gervais

(Richard Edward Gervais)

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 213 - 20 - 8158

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

5

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1924

8. AGE: Years Months Days If less than one day

19

1

29

hr.

min.

9. Birthplace Binghamton, N. Y.

(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Fairfield

12. Name Lee M. Gervais

13. Birthplace C o h o e s , N . Y .

14. Maiden Name Viola Walters

15. Birthplace O f t o n , N . Y .

16 (a) Informant Mr. L. M. Gervais

(b) Address 3216 Gwynns Falls Pkwy.

17 (a) Burial (b) Date thereof 9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto., Md.

19 (a) AUG 31 1943

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1943, to 8/30 1943, and that I last saw him alive on 8/30 1943.

Immediate cause of death Pulmonary edema

& cardiac decompensation
failed

Due to auricular fibrillation

Due to bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: same as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. Gervais

Address Union Hosp.

Date signed 8/30/43

affirmed by Howard J. Neale, M.D.

Correct age and maiden name of mother
64487835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2143 David Hill Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Hortense Bee Mason

3 (b) If veteran, name war

3 (c) Social Security Account No. 1

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Phillip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/08

8. AGE: Years Months Days If less than one day

33 34 9 21 hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

MOTHER / FATHER

12. Name Shepherd Bee

13. Birthplace Baltimore, Md.

14. Maiden Name Allice Rich

15. Birthplace Baltimore, Md.

16 (a) Informant Phillip Mason

(b) Address 2143 David Hill Ave

17 (a) Burial (b) Date thereof Aug 31, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 David Hill Ave

19 (a) Aug 31, 1943 (b) John H. Mason

VS 148

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1943. 1045 P

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-23 1943, to Aug-27 1943, and that I last saw her alive on Aug-27 1943.

Immediate cause of death

Peripheral vascular collapse

Duration 7 hrs.

Due to

Fever of unknown origin
? Encephalitis

Due to

? Atropine poisoning

Other Conditions

(none)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Paul O. Chaffield

Address

Johns Hopkins Hosp Date signed 8/28/43

G 07721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07721
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1136 N. Stricker

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1136 N. Stricker
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Della Neal

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

Conroy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 2, 18

8. AGE:

Years

Months

Days

If less than one day

45028

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Housekeeper

11. Industry or business

12. Name

George Neal

13. Birthplace

Maryland

14. Maiden Name

Jenny Thomas

15. Birthplace

Maryland

16 (a) Informant

Mary C. Thomas

(b) Address

1136 N. Stricker St.

17 (a)

Burial

(b) Date thereof

Sept. 3, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

Mr. Long & Co., Baltimore

(b) Address

1631 Daniel Hill Ave.

19 (a)

(b)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1943 at 8 A M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Tuber Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature Thomas J. Wolden

Medical Examiner.

Date signed 8-30-43

G 07722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07722
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland **BALTIMORE CITY.**
 (b) Street address **1505 WEST FRANKLIN STREET**
 (c) Hospital or institution: **NONE**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **x 19**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MARYLAND** (b) County
 (c) City or town **BALTIMORE CITY**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **1505 WEST FRANKLIN STREET**
 (If rural give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country

3 (a) FULL NAME

DAVID HENRY WASHINGTON.

3 (b) If veteran, name war

WORLD WAR #1.1917

3 (c) Social Security Account

No. 213-03-2785.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife **Carrie C.**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Aug. 21, 1903**8. AGE: Years **40** Months **-** Days **8** If less than one day hr. min.9. Birthplace **Baltimore, Md.**

10. Usual Occupation

Clevator operator

11. Industry or business

12. Name

George Washington13. Birthplace **Chattanooga, Tenn.**14. Maiden Name **Malinda Lyle**15. Birthplace **Lexington, Va.**16 (a) Informant **Carrie C. Washington**(b) Address **1505 St. Franklin St.**17 (a) **Burial** (b) Date thereof **Sept. 2, 1943**(c) Cemetery or crematory **Bell's Mt. Cem.**Location **Baltimore, Md.**18 (a) Funeral director **Mr. George W. Holland**(b) Address **1631 Duval St. S.W.**19 (a) **AUG 27 1943** (b) **Wm. L. Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **AUGUST 29 1943** at **9 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **JULY 11 1943** to **AUGUST 29 1943**, and that I last saw him alive on **AUGUST 29 1943**.

Immediate cause of death **CARCINOMIA OF THE STOMACH** Duration **4/26/43**

Due to **METASTASIS TO LIVER** 1943.

Due to

Other Conditions

(Include procedure within 3 months of death)
 Date of operation **APRIL 26, 1943**

Major findings of operations **CARCINOMIA & METASASIS**

of autopsy **NONE**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Geo. J. Clauter**Address **3013 ST. PAUL STREET** M. D.Date signed **8.29.**

G 07723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07723

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore(c) City or town PARKTON

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN TRUMAN SADLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-42

8. AGE:

Years

Months

Days

If less than one day

8

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

John Sadler

13. Birthplace

md.

MOTHER

14. Maiden Name

Goldie Turnbaugh

15. Birthplace

md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

MT. Zion

Location

Freeland, Md

18 (a) Funeral director

Jacob Hartenstein

(b) Address

New Freedom, Pa.

19 (a)

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1943, at 7:05 A M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1943 to Aug 30 1943 and that I last saw him alive on Aug 30 1943.

Immediate cause of death

Paroxysmic tachycardiaPrigick vascular collapseOther Conditions diarrhea
? nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John Hopkin Hop

Address

John Hopkin Hop

Date signed

8/30/43

Duration

1 da1 da8 hours3 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AUG 31 1943

Hartenstein William M

G 07724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07724
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4809 Hazelwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Pikesburg
(If outside city or town limits, write RURAL and give town)(d) Street No. 4809 Hazelwood Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Wilhelmina Frankenger

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

H. Henry Frankenger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22nd 1850

8. AGE: Years

92

Months

8

Days

8

If less than one day

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

12. Name

Jacob H. Klingler

13. Birthplace

Germany

14. Maiden Name

Caroline Hebrung

15. Birthplace

Germany

16 (a) Informant

Henry Frankenger

(b) Address

4809 Hazelwood Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept 2 43

(month) (day) (year)

(c) Cemetery or crematory

Jerusalem Luth.

Location

Balto. City Md.

18 (a) Funeral director

Tasachin Funeral Home

(b) Address

7401 Belair Rd.

19 (a)

(Date rec'd by registrar)

(b)

H. Frankenger

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30th 1943, at 9³⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1-1943 to Aug. 30 1943, and that I last saw him alive on Aug. 30 1943.

Immediate cause of death

Generalized arteriosclerosis.
Swelling - was not fatal.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

J. B. Boyle

Address 5317 Hayford Rd.

Date signed 8/31/43

AUG 31 1943

G 07725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07725

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

20
5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

- 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 410 N. Pulaski St.

(e) Citizen of foreign country? No (Yes or No)

3 (a) FULL NAME

Marie Stoker (Mrs. Marie Doretta Stoker) (Shilling)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

John J. Stoker

(c) If alive, years

7. Birth date of deceased (mo., day, yr.)

Dec - 18th 1882

8. AGE:

Years

Months

Days

If less than one day

60

8

12

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Home

11. Industry or business

FATHER

12. Name

Carl Shilling

13. Birthplace

Germany

MOTHER

14. Maiden Name

Doretta Logmann

15. Birthplace

Germany

16 (a) Informant

Mrs. Stoker

(b) Address

4023 Cranston Ave

17 (a)

Burial

(b) Date thereof

9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western

Location

Balto., Md.

18 (a) Funeral director

Mrs. Wilson & Son

2503 Edmondson Ave

AUG 31 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1943, to 8/30 1943, and that I last saw her alive on 8/28 1943.

Immediate cause of death

Hypertensive embolus
Heart failure

Due to

Hypertensive CVD.

Due to

Cardiac compensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Cohen

Address

University Hosp.

Date signed 8/30/43

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-70960 07726

BALTIMORE CITY HEALTH DEPARTMENT

G 07726

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 yr - 7 mos. - 22 days

(e) Length of stay in Baltimore (yrs., mos., or days)

41 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1336 Penn Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

Sarah Wilkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27-? (60?)

8. AGE: Years

60?

Months

?

Days

?

If less than one day

hr.

min.

9. Birthplace

Va.,

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name John Brown

13. Birthplace Va./

14. Maiden Name Adeline Brown

15. Birthplace Va.,

16 (a) Informant Baltimore City Hospitals

(b) Address

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept 2-1943 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director H. Brooks

(b) Address 1463 W. Carey St.

AUG 31 1943

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1943 at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7-42 19 to 8-29 19 43 and that I last saw him alive on 19

Immediate cause of death

Cardiac decompensation

Due to Rheumatic heart disease

Due to

Other Conditions Splenic artery (? due to old infection)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Paul H. H. H.

Address BCH

Date signed 8/29/43

M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07727

AB-89061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G 07727
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos. 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 70 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1827 N. Calvert St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Henry Van Dyke Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Annie (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1866

8. AGE: Years

77

Months

4

Days

2

If less than one day

hr.

min.

9. Birthplace Delaware

(Town, county, and state)

10. Usual Occupation

Unable to work

11. Industry or business

FATHER
MOTHER

12. Name James Johns

13. Birthplace Md.

14. Maiden Name

Lydia Clark

15. Birthplace

Delaware

16 (a) Informant Baltimore City Hospitals

(b) Address

Records

17 (a) Burial

(b) Date thereof Sept 7 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 8/31/43

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/43 19 to 8/30 1943.

and that I last saw him alive on 8/30 1943.

Immediate cause of death Prob. pul-

monary embolism in

coronary occlusion.

Due to H. A. S. C. disease

Due to

Other Conditions

Hem. arterioscler-

osis; chron. bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Sargman

Address

B C H

Date signed

8/30

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07728
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4000 Ayrdale Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Herman Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

35

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore Md

10. Usual Occupation

Clerk Post office

11. Industry or business

12. Name

Joe Schwartz

13. Birthplace

Latvia

14. Maiden Name

Leva

15. Birthplace

Russia

16 (a) Informant

Estelle Schwartz

(b) Address

4000 Ayrdale Ave

17 (a)

Burial

(b) Date thereof

9-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Workmen Circle

Location

Kehew Pat. Cemetery

18 (a) Funeral director

Joe Heine Inc

(b) Address

1739 E. Balto. St

19 (a)

8/31/43

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4000 Ayrdale Ave

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 31

1943

at

4:30 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from May 1943 to Aug 21 1943.

and that I last saw him alive on Aug 20 1943.

Immediate cause of death

Carcinoma lung, liver

Duration

4 mos.

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Biopsy done on gland carcinoma

of autopsy:

acute diagnosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Morris B. Schuster

M. D.

Address 54 S. Fulton Ave

Date signed

8-21-43

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH836 G 07729
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3412 Guilford Terrace

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3412 Guilford Terrace

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Marrieth Johnston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 30 1943 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Aug 30 1943

And that I last saw her alive on Aug 29 1943

Immediate cause of death

Cerebral Thrombosis

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Frank J. Geraghty

Address

2047 S. Calver St.

Date signed

8/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07730
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1248 Light St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1248 Light St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Henry Francis Huber

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

M

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Cath. A. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/30/1904

8. AGE:

Years

Months

Days

If less than one day

39

28

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Sheet Metal Worker

11. Industry or business

Ship yard.

FATHER
MOTHER

12. Name

Henry Huber

13. Birthplace

Md.

14. Maiden Name

Sophia Smith

15. Birthplace

Baltimore.

16 (a) Informant

Mrs C. A. Huber

(b) Address

17 (a)

Burial

(b) Date thereof 9/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

Fahy & Sons

(b)

8/31/43

1318 Light St.

19 (a)

Date read by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1943 to 1943

and that I last saw him alive on Aug 28 1943.

Immediate cause of death

Ventricular Fibrillation of Heart

Duration

10 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: mi

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

C. J. Shields MD

Address 1279 Delham St

Date signed 8/30/43

07731

BALTIMORE CITY HEALTH DEPARTMENT

G 07731

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore General Hosp. 7/23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 5 min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1124 Leadenhall St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Marie Sill

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. none

4 Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7-1942

8. AGE: Years Months Days If less than one day

9

23

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name John G. Sill

13. Birthplace Baltimore Md.

14. Maiden Name Joyce Wolfe

15. Birthplace Baltimore Md.

16 (a) Informant Esthel Sill (Aunt)

(b) Address 1124 Leadenhall St

17 (a) Burial (b) Date thereof Sept. 2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Rd.

18 (a) Funeral director Lilly & Zeigler INC

(b) Address 403 S. Wolfe St.

AUG 31 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1943, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1943, to Aug. 30 1943, and that I last saw h.e. alive on Aug. 30 1943.

Immediate cause of death Acute gastro-enteritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul A. Lukate

Address 1213 Light St. Date signed 8/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, PRINTING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

07732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07732

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **3411 Foster Avenue**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **6.0 yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **3411 Foster Avenue**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

HENRY NAGENBAST

3 (b) If veteran, name war

40

3 (c) Social Security No.

None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

WIDOWED6 (b) Name of husband or wife **ELIZABETH N**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 1, 1863**

8. AGE:

Years

Months

Days

If less than one day

79**9**

hr.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual Occupation

RETIRED

11. Industry or business

FATHER

12. Name **JOHN NAGENBAST**13. Birthplace **GERMANY**14. Maiden Name **?**15. Birthplace **GERMANY**16 (a) Informant **AGNES SCHULTZ (NIECE)**(b) Address **1615 NORMAN AVE.**17 (a) **Burial** (b) Date thereof **Sept 3-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Holy Redeemer**Location **Belair Road**18 (a) Funeral director **Lilly and Ziehl, INC**(b) Address **403 S. Wolfe St.**19 (a) **AUG 31 1943** (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 31, 1943** at **7:55 A.M.**

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature **H. L. Wollenmeyer** M.D.Date signed **8-31-43**

G 07733
MD-83273BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07733
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 10 E. Hamburg St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Annie Fitzpatrick

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-03-5724

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife John Fitzpatrick

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1896

8. AGE: Years Months Days If less than one day

46

9

6

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business General Chemical Co.

12. Name Joseph King

13. Birthplace Baltimore, Maryland

14. Maiden Name Augusta Deal

15. Birthplace Baltimore, Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Daniel (b) Date thereof Sept. 2, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory Cedar Hill Cem.

Location 9.9. Co. Md.

18 (a) Funeral director J. Howard Evans

(b) Address 1400-22 S. Charles St.

19 (a) AUG 31 1943 (b) Registrar William H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1943 to 8/30 1943 and that I last saw her alive on 8/30 1943.

Immediate cause of death

Cardiac failure
Due to Atherosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. J. Sargman

Address 10 C.H. Date signed 8/30/43

Duration 24 hr.

25 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN BLOCK LETTERS. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 07734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07734

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1010 N. Carlton St.

(c) Hospital or institution: _____

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

3 (a) FULL NAME

Infant Knight

3 (b) If veteran, name war _____

3 (c) Social Security Account
No. _____

4. Sex

Male

5. Color or race

Cal.

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8/24/43

8. AGE:

Years

Months

Days

If less than one day

5

hr.

9. Birthplace

Baltimore City Md.
(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Theodore Roosevelt Knight

13. Birthplace

Martin Co. N.C.

14. Maiden Name

Rosie Lee

15. Birthplace

Pitt Co. N.C.

16 (a) Informant

Rosie Lee Knight

(b) Address

1010 N. Carlton St.17 (a) Burial

(b) Date thereof

Aug. 31-43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

914 Zion Cem

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 W. Schomels St.

19 (a)

(Date of death)

AUG 31 1943Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County _____(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street 1010 N. Carlton St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2910:43 AM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1943 to Aug 29 1943 and that I last saw him alive on 8/29 1943.

Immediate cause of death

Premature BirthDuration 5 days

Due to _____

Due to Not Known

Other Condition _____

(Include pregnancy within 6 months of death)

Date of operation none

Major findings of operation: _____

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

M

(c) Where did injury occur? _____

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____

(Specify type of place)

While at work? _____

(e) Means of injury _____

23. Signature

J. T. Gurnea MD

Address

1010 N. Carlton St.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07735

BALTIMORE CITY HEALTH DEPARTMENT

G 07735

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-14-9104

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

8.27

1943, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8.20 1943, to 8.27 1943, and that I last saw him alive on 8.27 1943.

Immediate cause of death

Cardio-Vascular -
Renal Disease

Due to

Due to

Other Conditions Accompaniment

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. P. Lusher

Address 825 N. Fremont

Date signed 8.28.43

6 07736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157d Registered No. 6 07736

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1/2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 13 1/2 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 19 Merrymount Road

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Female Baby McClain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 27, 1943

8. AGE: Years Months Days If less than one day
13 hr. 30 min.9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation Infant

11. Industry or business

12. Name Walter Judson McClain

13. Birthplace Philadelphia - Pa.

14. Maiden Name Virginia Day Ashmead

15. Birthplace Philadelphia - Pa.

16 (a) Informant Mother

(b) Address

17 (a) Removal (b) Date thereof Aug 28, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Carnegie's Laboratory

Location Wolfson Madison St.

18 (a) Funeral director

(b) Address

19 AUG 31 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1943, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 27, 1943, to August 28, 1943, and that I last saw her alive on August 28, 1943.

Immediate cause of death
Congenital anomaly.

Due to microcephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John B. Murray, Jr.

Address 9 E. Chase St. Date signed Aug 28, 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07737

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 820 Rapolla St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Weber

83003

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-07-9958

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or divorced.
sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 4, 1885

8. AGE: Years 57 Months 9 Days 26 If less than one day hr. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

crane operator

11. Industry or business

FATHER
MOTHER

12. Name William Weber

13. Birthplace Md.

14. Maiden Name Sophia Yoeman

15. Birthplace Md.

16 (a) Informant Hospital records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 2, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Calvary Lawn
Location Calvary Md.

18 (a) Funeral director P. H. H. Funeral Home

(b) Address 200 S. Orleans St.

AUG 31 1943

(b)

Registrar

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1943 11:50AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1943 to Aug. 30 1943

and that I last saw him alive on Aug. 30 1943

Immediate cause of death

Pulmonary tuberculosis

Duration

4 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Paul Hest Date signed 8/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07738
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Fayette + Calhoun Sts*
(c) Hospital or institution *Franklin Square Hosp.*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 yr.*
(e) Length of stay in Baltimore (yrs., mos., or days) *6 mos.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1508 W. Fayette St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Goldie Ethel Lovejoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-28-43

8. AGE:

Years

Months

Days

If less than one day

0

7

3

hr.

min.

9. Birthplace

Baltimore

md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Wm M. Lovejoy

13. Birthplace

W. Va

14. Maiden Name

Lovejoy, Fessie

15. Birthplace

W. Va

16 (a) Informant

Wm M. Lovejoy

(b) Address

1508 W. Fayette St

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Aug 31 - 1943

(c) Cemetery

Chapin

Location

Chapin W. Va

18 (a) Funeral director

Robt O. B. M. Walters

(b) Address

Pratt Stricker St

AUG 31 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-31

1943, at

11A M

21. I certify that death occurred on the date above stated; that I attended deceased from *8-31* 1943, to *8-31* 1943, and that I last saw her alive on *8-31* 1943.

Immediate cause of death

Broncho pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm M. Lovejoy

Address

422 W. Pratt St

G 07739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07739

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Cathedral Madison St.

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

GEORGE H. MULLER

3 (b) If veteran, name war

World War #1

3 (c) Social Security Account

No. 303-03-0331

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 25-1897

8. AGE:

Years

Months

Days

If less than one day

454685

hr.

min.

9. Birthplace

Elizabeth New Jersey

(Town, county, and state)

10. Usual Occupation

Radio-Operator

11. Industry or business

FATHER
MOTHER

12. Name

Charles Mueller

13. Birthplace

U. S. A.

14. Maiden Name

Mary High

15. Birthplace

U. S. A.

16 (a) Informant

Julian Mueller

(b) Address

201 Zander Ave Roselle Park

17 (a)

Burial

(b) Date thereof

Sept 3-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hollywood Memorial

Location

Bank - Springton New Jersey

18 (a) Funeral director

Ellsworth Amacost

(b) Address

3911 Liberty Heights Ave

19

AUG 31 1943Huntington Williams, MD

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

Union

(c) City or town

Roselle Park

(If outside city or town limits, write RURAL and give town)

(d) Street No.

211 Belvedere Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 30 1943, at 5:50 PM

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Dr. J. Wallenmeyer M.D.

Date signed

8-31-43

G 07740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07740
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED

(a) State Md (b) County Balto.(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)(d) Street No. 17 Walker Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Berry

3 (b) If veteran, name war

1918

3 (c) Social Security Account

No. 216-07-9514

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Aug 12-1892

8. AGE: Years Months Days If less than one day
51 18 hr. min.9. Birthplace Norfolk Va
(Town, county, and state)10. Usual Occupation Electrician

11. Industry or business

12. Name Jerminal Berry13. Birthplace Va14. Maiden Name Gallops15. Birthplace Va.16 (a) Informant Patricia H. Caughy(b) Address 20 Walker Ave. Pikesville Md.17 (a) Burial (b) Date thereof 9/1/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto NationalLocation 5500 Frederick Rd18 (a) Funeral director Frank H. Newell Inc(b) Address Pikesville Md.(c) Date of registration Aug 11 1943 Registrar Harvey W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1943 at 6:05 PM21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 8/29/43 at 5:40 P.M.(b) Where did injury occur? Woods Bay Country - 1835 N. Port St(c) Did injury occur at home, on farm, industrial place, in public
place? Industrial While at work? Yes(d) Means of injury Electrocution23. Signature Harvey W. Williams M.D.Date signed 9/24/43 Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Parkman G 07741

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) none

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind

(b) County

HOWARD

(c) City or town

Greenwood

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1943

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace Greenwood Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Dr. J. P. Parkman

13. Birthplace

N. Car.

14. Maiden Name

Annie Bonham

15. Birthplace

N. Carolina

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

Sept. 1, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Grove

Location

Greenwood, Howard

18 (a) Funeral director

H. M. Snyder

(b) Address

1001 1st St. N.E.

19 (a)

Aug 31 1943

(Date rec'd by registrar)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1943 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Aug 31 1943, and that I last saw him alive on Aug 31 1943

Immediate cause of death

Passive Hypertension

Due to

Infarction

Due to

Stroke

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Canton Wick

Address

1001 1st St. N.E.

Date signed

Aug 31 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07742

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *42nd + York Rd.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) *45 yrs.*

3 (a) FULL NAME

Margaret H. Gunter

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

65

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Maid

11. Industry or business

FATHER
MOTHER

12. Name *Unknown*

13. Birthplace *Unknown*

14. Maiden Name *Susan*

15. Birthplace *Va.*

16 (a) Informant *H. Herbert Knox*

(b) Address *916 Fremont Ave*

17 (a) *Buried* (b) Date thereof *9-2-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Locustville, Va.*

Location *Accomac Co. Va.*

18 (a) Funeral director *Charles G. Cooper*

(b) Address *514 N. Calhoun St.*

AUG 31 1943

(b) *H. Herbert Knox*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County —

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4101 42nd + York Rd.*

(If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 30, 1943* at *4:30 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from 19 — to *Aug 29, 1943*

and that I last saw her alive on *Aug. 29, 1943 (12 M)*

Immediate cause of death

Interstitial Nephritis
Uremia

Due to *Arteriosclerosis*

Due to *Heart Complications*

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —

(Specify type of place)

(e) Means of injury —

23. Signature *Wm. M. Lannabaker*

Address *2740 St. Paul St* Date signed *Aug 31, 1943*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07743

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 334 Street

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (g) FULL NAME Elizabeth Ruthenford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Calvin C. Ruthenford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1879

8. AGE: Years Months Days If less than one day

64

6

6

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Mr. Koron

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant

(b) Address

17 (a) Removal (b) Date thereof 9-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Union Memorial

Location 20-20

18 (a) Funeral director J. V. Kachner

(b) Address 2301 Edmondson Ave

19 SEP 1 1943 (b) Thurston Williams

VB 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1810 St. Paul St

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1943 to Aug. 31 1943, and that I last saw her alive on Aug. 31 1943.

Immediate cause of death CORONARY ARTERY OCCLUSION

Due to ARTERIOSCLEROSIS

Due to DIABETES MELLITUS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John A. Kestell Jr.

Address Union Memorial Hosp Date signed 8-31-43

Duration

Question

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07744

Registered No.

G 07744

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 853 Woodard ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 853 Woodard St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Wellmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

74

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

Mary
853 Woodard

17 (a) Burial

(b) Date thereof Sept 1 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Parkwood Cem.

Location

18 (a) Funeral director

(b) Address

Joseph I. Cannakes Inc.
602 Washington St.

19 SEP 1 1943

(b)

Washington William

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 27 1943 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1943 to Aug. 27 1943 and that I last saw him alive on Aug. 27 1943

Immediate cause of death

Acute Cerebral Apoplexy

Duration

Due to

Cerebral Arteriosclerosis?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

100 Y E. Pratt St.

Date signed

8/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07745

Registered No.

124B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07746

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-29-1943 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-1943 to 8-29-1943 and that I last saw him alive on 8-28-1943.

Immediate cause of death

Cardio-Renal-Vascular
Disease

Duration

3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Eugene A. Page

Address

1516 N. Mount St.

Date signed 8-31-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07747
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 828 N. Stricker St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 828 N. Stricker St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph Smith

3 (b) If Veteran, name war

3 (c) Social Security Account
No.

4. Sex

male colored

5. Color or race

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Louise Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 - 1867

8. AGE: Years Months Days If less than one day
26 2 23 hr. min.9. Birthplace A. A. County
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Perry Smith

13. Birthplace Anne Arundel County

14. Maiden Name unknown

15. Birthplace Anne Arundel County

16 (a) Informant Louise Smith

(b) Address 828 N. Stricker St

17 (a) Sept 2 (b) Date thereof 9/2-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory location
Bureau
Cathedral Cemetery

18 (a) Funeral director Thomas H. Bushnell

(b) Address 528 Laurens St.

19 SEP 1 1943
Filed for record by

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1943 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943 to Aug 31 1943 and that I last saw him alive on Aug 30 1943

Immediate cause of death

myocardial

Duration

6 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation none

Major findings of operations

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E. J. Camper

Address 639 N. Carey St Date signed 8-31-43 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

077474
436169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

077474
1270

Registered No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>D.C.</u> (b) County	
(b) Street address		(c) City or town <u>WASHINGTON</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution: <u>JOHNS HOPKINS HOSPITAL</u>		(d) Street No. <u>2121 K. St. N.W.</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country? (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days)		If yes, name country	

3 (a) FULL NAME Ellsworth M Bruce

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-62

8. AGE: Years 80 Months Days If less than one day hr. min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Robert Bruce

13. Birthplace VA

14. Maiden Name Eliza Carpenter

15. Birthplace VA

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-2-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Harmony Cemetery
Location Washington, D.C.

18 (a) Funeral director Morgan & Sons Inc

(b) Address 424 G Street N.W.

19 OCT 11 1944 (Date of registration) Washington, D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1943 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 11 1943 to AUG 31 1943, and that I last saw him alive on AUG 31 1943.

Immediate cause of death
Heart failure
Due to uremia
Due to benign prostatic hypertrophy
Other Conditions thalassemia
hemolytic anemia
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations:

Duration
10 yrs.
PHYSICIAN
Underline the cause to which death should be charged statistically.

of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edw. J. Richardson, Jr.
Address Johns Hopkins Date signed 9/31/43

07743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07748

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

130

(e) Length of stay in Baltimore (yrs., mos., or days)

130

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa.

(b) County

Franklin

(c) City or town

Quincy

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No.

(Yes or No)

If yes, name country

3 (a) FULL NAME

Eva F. Good

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

White

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

Newton Good

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-1-1877

8. AGE:

Years

Months

Days

If less than one day

66

6

0

hr.

min.

9. Birthplace

Quincy, Franklin Co., Pa.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Franklin McCleary

13. Birthplace

Franklin Co., Pa.

14. Maiden Name

Jennie Bean

15. Birthplace

Franklin Co., Pa.

16 (a) Informant

Dennis W. Good

(b) Address

Quincy, Pa.

17 (a)

removal

(b) Date thereof

8/1/1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Hill

Location

Waynesboro Pa.

18 (a) Funeral director

H. H. H. H. H.

(b) Address

27 S. Church St. Waynesboro Pa.

19 (a)

SEP 1 1943

(b) Registrar

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-1-1943, 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1943 to 9-1-1943, and that I last saw her alive on 9-1-1943.

Immediate cause of death

Cholangitis

Due to

Cholecyst gastrostomy

Due to

Ca of Head of Pancreas

Other Conditions

Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

8-26-43

Major findings of operations

Ca of Head

of pancreas

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Murgatroyd Jr.

Address 22 E. University Pk. Pte signed 9/1/43

Duration

2 days

17 days

21 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bethlehem-Fairless S.B. Corp. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 714 Bartlett Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Leslie Deickman

(Leslie Linwood Deickman)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Viola Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27/1904

8. AGE: Years Months Days If less than one day

36

36

11

4

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Ass't. Foreman11. Industry or business Bethlehem Fairfield12. Name Frank Emil Deickman13. Birthplace Germany14. Maiden Name Barbara C. Fritz15. Birthplace Baltimore, Md.16 (a) Informant Mrs. Viola M. Deickman(b) Address 714 Bartlett Ave.17 (a) Burial (b) Date thereof 9/3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.Location Balto., Md18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Baltimore, Md.19 (a) SEP 11 1943 Washington Williams

VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1941 at 12:30 PM21. I certify that I took charge of the remains described above, held an autopsy, injury, & inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Crushed skull.

Due to

Other Conditions Fractured neck & ribs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-31-43 at 12:30 P. M.(b) Where did injury occur? Beth.-Fair. Shop - S. Corp.(c) Did injury occur at home, on farm, industrial place, in public place Industrial While at work? Yes(d) Means of injury Crushed between cars (new)23. Signature Howard J. Maseis M.D.

Medical Examiner.

Date signed 9/2/43

The
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07750
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1205 Walnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Walnut St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

NORA WRIGHT RINE

- 3 (b) If veteran, name war none 3 (c) Social Security Account No. none

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced married

- 6 (b) Name of husband or wife Charles L. Rine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1966

8. AGE: Years 77 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Wm. T. Bright

13. Birthplace Va.

14. Maiden Name Virginia Grayatt

15. Birthplace Va.

- 16 (a) Informant Mr. Charles T. Rine

- (b) Address 1205 Walnut Ave.

- 17 (a) Burial (b) Date thereof 9/2/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

- 18 (a) Funeral director WM. J. TICKNER & SONS

- (b) Address Balto., Md.

- 19 (a) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 19 43 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from April 29 19 40 to Aug. 29 19 43
and that I last saw h or alive on Aug. 29 19 43

Immediate cause of death
Cerebral Hemorrhage

Duration
2 days

Due to
Arteriosclerosis

Due to

Other Conditions
Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

- (e) Means of injury

23. Signature George H. Kuyp
Address 3030 Edmondson Ave. Date signed 8/31/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

SEP 1 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07751
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Talbot Road, City
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elyse Boone Sheldon

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1859

8. AGE: Years 84 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Indiana (Madison)
(Town, county, and state)

10. Usual Occupation retired school teacher

11. Industry or business

12. Name William Wharton

13. Birthplace Madison Indiana

14. Maiden Name Laura Ella Lodge

15. Birthplace Indiana

16 (a) Informant Mrs. Geo. H. Stapp (niece)

(b) Address 2411 Talbot Road, Balto

17 (a) Cremation (b) Date thereof 9/1/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Crematory
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 1 1943 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1943 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7:30 1943 to midnight 8/30 and that I last saw her alive on this day 8/30
Immediate cause of death

Coronary thrombosis

Due to Arteriosclerotic Coronary

Due to

Other Conditions Serious

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Johna Westhoff
Address Union Memorial Hosp. Date signed 8-30-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07752
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 547 Roberts St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph Lopez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Bernice

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 10-10-06

8. AGE:

Years

Months

Days

If less than one day

36

10

20

hr.

min.

9. Birthplace Puerto Rico

(Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

12. Name Pedro Lopez

13. Birthplace P.R.

14. Maiden Name Hilda?

15. Birthplace P.R.

16 (a) Informant Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 3, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director Mr. George W. Holland

(b) Address

19 SEP 1-1943 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1943 to Aug. 30, 1943 and that I last saw him alive on Aug. 30, 1943

Immediate cause of death

Staphylococcal Sepsis

Due to Staphylococcal Endocarditis

Due to

Other Conditions Barthrod's Left Shoulder

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Abraham Genesin

Address Johns Hopkins Hospital Date signed Oct 11, 1943

Duration

3 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

Spec. - 1-10-21 - M&T - 1909 Ed.

G 07753

HEALTH DEPARTMENT - CITY OF BALTIMORE

G 07753

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Mc Culloch St WARD)

2. FULL NAME

Mary (Mamie) T. Smith

(a) RESIDENCE NO.

1416 Mc Culloch St WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S. if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

830

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col. 5 Widow Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced Widow HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year) Nov. 9 - 1866

7 AGE Years 76 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Washington DC

10 NAME OF FATHER Joseph Dalton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. DC

12 MAIDEN NAME OF MOTHER Mrs. Mary Dunbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington DC

14 Informant Mrs. Blanche Day (Address) 1416 Mc Culloch St

15 SEP - 1 1943 Huntington

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 - 1943

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1942 to Aug. 29 1943, that I last saw her alive on Aug. 29 1943, and that death occurred, on the date stated above, at 9-11 m.

The CAUSE OF DEATH* was as follows: Infantile of age

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. H. Magness M. D. 8/31/43 Address 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Int. Auburn

DATE OF BURIAL

9/2/1943

UNDERTAKER

George J. A. Gibbons Address David Hill Ave

G 07754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07754

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Prosser Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1627 Division St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George Gaines

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-818-3880

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary Stewart Gaines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1909

8. AGE: Years Months Days If less than one day

34 7 27 hr. min.

9. Birthplace Bridgeville, Del.

(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

12. Name Geo. O. Gaines

13. Birthplace Poplar, Md.

14. Maiden Name Evelyn Smith

15. Birthplace Truxton, Md.

16 (a) Informant Mary Stewart Gaines

(b) Address 1627 Division St

17 (a) (b) Date thereof 8-1-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cypress Memorial Pk

Location Baltimore, Md.

18 (a) Funeral director Archibald R. Yaddis

(b) Address 2101 Mc Carthy St

19 (a) SEP 1 1943

(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1943 at 5:20 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractures 5-6 Thorsacic
vertebrae

Other Conditions Multiple lacerations

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-29-43 at 3:40 P. M.

(b) Where did injury occur? Green Spring Ave. Towson

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes

(d) Means of injury Riding motor cycle, crashed into

23. Signature Howard J. Williams M.D.

Medical Examiner.

Date signed 8/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-70040

G 07755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07755

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **3040 Eastern Ave.,**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **6 mos., 24 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **30 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2404 Huron St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Willie Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Sarah (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 17-1895

8. AGE:

Years

Months

4

Days

12

If less than one day

hr.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

John Garrett

13. Birthplace

S.C.

14. Maiden Name

Martha Mance

15. Birthplace

S.C.

16 (a) Informant

Baltimore City Hospitals

(b) Address

Records

17 (a)

Burial

(b) Date thereof

9-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Calvary Cem

Location **Baltimore County Md**

18 (a) Funeral director

William A. Jackson

(b) Address

916 Penna ave

SEP 1 1943

(b)

Thurston Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/19

1942 at 12:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from **8/5** **1942** to **8/19** **1942**, and that I last saw **him** alive on **8/19** **1942**.

Immediate cause of death

Emphysema

Duration

2 wks

Due to

Due to

Other Conditions

Auto accident
Heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Hall

Address

B.C.H.

Date signed

8/19/42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07756

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH/46

G 07756
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 1 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-31

1942, 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/1942 to 8/31/1942, and that I last saw him alive on 8/31/1942.

Immediate cause of death

Due to

Due to

Other Conditions

Include pregnancy within 3 months of death

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

7757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07757

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP 1 1943

VS 2

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G 07758
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 550 W Lee St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 3 yrs

3 (a) FULL NAME

Hester Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female Negro

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 Months 2 Days 3 If less than one day

9. Birthplace

Baltimore Md

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

SEP 1 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from April 22, 1943, until Aug 28, 1943, and that I last saw her alive on Aug 28, 1943.

Immediate cause of death

Pulmonary carcinoma
Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Watts

Address

Date signed 8/31/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07759

93d

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1719 W. Lexington St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

19 yrs

3 (a) FULL NAME

Charles Fogg Sr.

3 (b) If veteran, name war

Worlds War I

3 (c) Social Security Account

No. 213-01-4197

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Minnie Fogg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 19, 1891

8. AGE: Years

52

Months

Days

If less than one day

hr.

min.

9. Birthplace

Louisburg N.C.

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

See Fogg

13. Birthplace

Louisburg N.C.

14. Maiden Name

Betty

15. Birthplace

N.C.

16 (a) Informant

Minnie Fogg

(b) Address

1719 W. Lexington St.

17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof

Sept. 1, 1943

(c) Cemetery or crematory

National Cem.

Location

18 (a) Funeral director

Mr. Katex R. Williams

(b) Address

9229 Schroeder St

19 (a) SEP 1 1943

(date rec'd by Registrar)

Funeral Home, Inc.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1719 W. Lexington St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 28th 1943 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/18 1943 to 8/28 1943.

and that I last saw him alive on 8/28 1943.

Immediate cause of death

Hypertensive & Type Heart Disease

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Not done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Iron Pipe

23. Signature

Iron Pipe

Address

601 N. Calhoun St

Date signed

9/30/43

Gilkes

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07760

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **3316 Royce Ave**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

27 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **3316 Royce Ave**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Jacob Bulmash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife **Dora**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1882**

8. AGE: Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Poultry Dealer

MOTHER FATHER

12. Name **Aaron Bulmash**

13. Birthplace **Russia**

14. Maiden Name **Yetta Leah Klapko**

15. Birthplace **Russia**

16 (a) Informant **Aaron Bulmash**

(b) Address **3316 Royce Ave**

17 (a) **Burial**

(b) Date thereof **Sept 1, 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **Hebrew Mt Carmel Road**

Location **German Hill Road**

18 (a) Funeral director **Sol Levinson & Bros**

(b) Address **1124 1126 W North Ave**

MEDICAL CERTIFICATION

12.05

20. DATE OF DEATH **Sept 1, 1943** at **A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **6-15** 19**43** to **Sept 1** 19**43** and that I last saw him alive on **19**

Immediate cause of death

Cancer of Stomach

Duration

3 m

Due to

Due to

Other Conditions

Chronic Ulcers, 34

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. J. Baylin

Address **2040 Eucaly**

Date signed **9/6/43**

SEP 1 1943

(Date)

(b)

Registrar

Harold William, M.D.

VS 124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

07761

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1511 Cherry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Anna Bertha Webb

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Wylie Webb

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

June 21, 1896

8. AGE: Years Months Days

47

2

10

If less than one day

hr.

min.

9. Birthplace

Curtis Bay

10. Usual Occupation

Housework

11. Industry or business

FATHER
MOTHER

12. Name

John Kosar

13. Birthplace

Bohemia

14. Maiden Name

Marie Bumba

15. Birthplace

Bohemia

16 (a) Informant Mr Wylie Webb

(b) Address 1511 Cherry St

17 (a) Burial (b) Date thereof 9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

Annapolis Rd

18 (a) Funeral director

William M. Marek

(b) Address

715 Light St.

19

SEP

1 1943

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Curtis Bay

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1511 Cherry St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1943 at 2⁰⁰ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1943 to Aug 30 1943 and that I last saw him alive on Aug 30 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

2 days

Due to

Hypertension

4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Rose D. Harky

Address

4700 Reisterstown

Date signed

9/3/43

G 07762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07762
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

1608 Latrobe St. 12-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 Latrobe St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Eugene Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Mary J. Edwards

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

31

hr.

min.

9. Birthplace S. Carolina

(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER

12. Name Earl Edwards

13. Birthplace S. C.

14. Maiden Name Anna Campbell

15. Birthplace S. C.

16 (a) Informant Mary J. Edwards

(b) Address 1608 Latrobe Street

17 (a) Removal (b) Date thereof Sept 1, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Chesaw S. Carolina

18 (a) Funeral director 1175 Robert A. Elliott & Co.

(b) Address 1129th Caroline St.

19 (a) Registrar

Signed by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1943, at 6:15 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Rheumatic Cardio-vascular

Disease

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury

23. Signature Hugh B. McLaughlin M.D.

Date signed 8/31/43

Medical Examiner

07763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07763

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
University Hospital. 17-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 812 Druid Hill Avenue
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

SHIRLEY DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 19428. AGE: Years Months Days If less than one day
19 9 1 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation None

11. Industry or business

12. Name Nellie Davis13. Birthplace N.Y.14. Maiden Name Carthelia Pettiford15. Birthplace N.C.16 (a) Informant Miss Sally Pettiford(b) Address 812 Druid Hill Ave.17 (a) Burial (b) Date thereof 9/31/1943(c) Cemetery or crematory St. Calvary Cemetery, Baltimore, Md.Location Roxboro, N.C.18 (a) Funeral director Adolphus Hight(b) Address 917 Druid Hill Ave.19 SEP 1 1943 Registrar William H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1943 at 12:05 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Crushing of pelvis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-30-43 at 11:30 A. M.(b) Where did injury occur? Druid Hill & Biddle St.(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No(d) Means of injury Pedestrian struck by streetcar.23. Signature H. J. Wallenmeyer, M.D.Date signed 8-31-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 02764

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 31st Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME HENRY G. MORROW

3 (b) If veteran, name war
Sp. Am. War

3 (c) Social Security Account
No. -

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Martha A. Hickson
(Deceased)

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1881

8. AGE: Years 62 Months 7 Days 7
If less than one day _____ hr. _____ min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Bricklayer, retired

11. Industry or business _____

12. Name Henry Morrow

13. Birthplace Baltimore, Md.

14. Maiden Name MOE Ruth Grant

15. Birthplace Shenandoah, Va.

16 (a) Informant Records, U. S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Sept 5 - 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St
SEP 1 - 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 31, 1943 at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9, 1943 to Aug. 31, 1943, and that I last saw him alive on Aug. 31, 1943.

Immediate cause of death

Carcinoma of the pancreas

Duration
Unk.

Due to _____

Due to _____

Other Conditions Suppurative pilephle-
bitis; multiple liver abscesses;
infarction of myocardium
(Include pregnancy within 6 months of death)

Date of operation None

Major findings of operations _____

of autopsy As above

Unk.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work?
(Specify type of place)

(e) Means of injury _____

23. Signature Emerson Y. G. G. G.

Address Baltimore, Md.

Date signed 8/31/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

07765

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town

Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. *122*

So Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Paul Westbury Jr

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No.

NONE

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Aug 18 1943

8. AGE:

Years

Months

Days

If less than one day

7

18

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Paul Westbury

13. Birthplace

14. Maiden Name

Ida Keene

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

Baltimore

18 (a) Funeral director

(b) Address

William Cook Inc

19 (a)

(b)

William Cook Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/31

19 *43*, at *10⁰⁰* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *8/31* 19*43*, to *8/31* 19*43*, and that I last saw him alive on *8/31* 19*43*.

Immediate cause of death

Cardiac failure

Due to

Sepsis

Due to

Acute pharyngitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Penland

M. D.

Address

Univ. Hosp.

Date signed *8/31/43*

SEP 1 1943

G 07766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07766

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 612 E. Baltimore St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME JOSEPH LONBACRE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

72

hr. min.

9. Birthplace

Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

William H. Longacre

13. Birthplace

MOTHER

14. Maiden Name

William Conner

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

SEP 1 - 1943

(b)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1943 at 3:30 M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Crushing of left leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 8-27-43 at 3:15 P.M.(b) Where did injury occur? in front of 5115 Park(c) Did injury occur at home, on farm, industrial place, in public
place? Yes While at work? no(d) Means of injury pedestrian struck by motor23. Signature H. J. Wallenmeyer M.D.Date signed 8-31-43

07767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07767
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2310 Callow ave.*

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

James T. Boyle

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. *412-10-9853*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

May 5, 1907

8. AGE:

Years

Months

Days

If less than one day

*36**3**26*

hr.

min.

9. Birthplace

Christianburg VA
(Town, county, and state)

10. Usual Occupation

*Pipe Fitter*11. Industry or business *Deliber - Faugner S. B. Corp.*

FATHER

12. Name

Thomas Boyle

13. Birthplace

Ireland

14. Maiden Name

Maido J. Handy

15. Birthplace

Cumberland Md.

16 (a) Informant

John P. Boyle

(b) Address

*1711 Linden Ave*17 (a) *Burial*

(b) Date thereof

9/1/43

(c) Cemetery or crematory

St. Joseph City

Location

St. Joseph City

18 (a) Funeral director

William J. Smith

(b) Address

*1219 St. Paul St*19 *SEP 1 - 1943*

(Date read by registrar)

(b) *Huntington Williams, M.D.*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-31-1943* *8:55 PM*21. I certify that I took charge of the remains described above, held an
Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *8/31/43* at *2:45 PM*(b) Where did injury occur *Del. - Faugner S. B. Corp.*(c) Did injury occur at home, on farm, industrial place, in public
place? *Industrial* While at work? *yes*(d) Means of injury *Fell down hole of ship*23. Signature *Howard J. Williams* M.D.Date signed *9/1/43* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07768

JL - 73734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07768

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 529 McMechen St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ross Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

M

C

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1906

8. AGE: Years

Months

Days

If less than one day

37

1

22

hr.

min.

9. Birthplace S. C.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
MOTHER

12. Name

James Saunders

13. Birthplace

N. C.

14. Maiden Name

Lottie Carter

15. Birthplace

S. C.

16 (a) Informant

Hospital Record

(b) Address

17 (a)

Burial

(b) Date thereof

9 1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary Cem

Location

A. A. Co

18 (a) Funeral director

R. A. Sanders

(b) Address

1412 E. Preston St

SEP 1-1943

(b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-27

1943 at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1942 to 8-27 1943.

and that I last saw him alive on 8/27 1943.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

No Aut

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Hatt

Address

DCH

Date signed

8/20/43

G 07769

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07769
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

852 W 34th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Frances S. Zepp

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife

James O. Zepp

6 (c) If alive, give age

66 1/2 years

7. Birth date of deceased (mo., day, yr.)

July 31, 1880

8. AGE: Years

63

Months

Days

Less than one day

hr.

min.

9. Birthplace

Maryland

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

? Sullivan

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Henrietta ?

15. Birthplace

Maryland

16 (a) Informant

James O. Zepp

(b) Address

852 W 34th St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept 4/43

(c) Cemetery or crematory

Grundy Ridge

Location

Pikesville, Md

18 (a) Funeral director

Chenavels & Son

(b) Address

3615-17 Chestnut Ave

19 (a)

VS 1

(b)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

852 W 34th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1943, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from March 1943, to Sept 1, 1943.

and that I last saw her alive on 3:15 AM Sept 1/43

Immediate cause of death

Coronary thrombosis short
Heart failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Leonard Wallenstein

Address

898 W 36th St

Date signed 9/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07770
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2117 Summers
(c) Hospital or institution Crawford Home 81
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Richmond
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Timothy M. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

Sophie M. Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-10-1867

8. AGE:

Years

Months

Days

If less than one day

77

5

10

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Edward Kelly

13. Birthplace

Ireland

14. Maiden Name

Mary Kelly

15. Birthplace

Ireland

16 (a) Informant

Kathleen Jay

(b) Address

3325 Richmond

17 (a) Burial

(b) Date thereof

9-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

18 (a) Funeral director

Leonard J. Quirk

(b) Address

5325 Crawford St.

SEP 1 1943

(b) Harold W. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1943 at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 13 1943 to Aug 30 1943 and that I last saw him alive on Aug 16 1943.

Immediate cause of death Coronary

arteriosclerosis

Due to senile degeneration

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial plant, in public place? (Specify type of place) While at work?
(e) Nature of injury Heart

23. Signature

Address Charles R. Rendell Date signed _____ M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07771

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Hilkens & Catondines*
(c) Hospital or institution: *St. Agnes Hospital* 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County
(c) City or town *Brooklyn*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3703 - 2nd St.*
(If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Albert Kempel

3 (b) If veteran, name war

3 (c) Social Security Account No. *-*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Wife - Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-12-1890

8. AGE:

Years *53* Months *0* Days *20* hr. min.
If less than one day

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Fireman

11. Industry or business

Baltimore City

FATHER

12. Name

Charles (Rev.)

13. Birthplace

MD.

MOTHER

14. Maiden Name

Fatie Prince (Rev.)

15. Birthplace

MD.

16 (a) Informant

Helen M. Kempel

(b) Address

3703 2nd St Brooklyn

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof *9-4-1943*
(Month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

A.A.C.

18 (a) Funeral director

Bernard C. Hinkle

(b) Address

131 E. 7th St

SEP 1-1943

(Date rec'd by registrar)

William Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 1, 1943* 10:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from *8-28-1943* to *9-1-1943*, and that I last saw *deceased* alive on *9-1-1943*.

Immediate cause of death

Intestinal obstruction

Due to

1. Intestine

Due to

Perforated diverticulitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. J. Byrnes

Address

St. Agnes Hosp

Date signed

9/1/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

07772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH166 G 07772
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va

(b) County

Norfolk County

(c) City or town

Portsmouth

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1120 Richmond Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

THOMAS R WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account

No. 231-03-2442

4. Sex

m

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Lillie Mae Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1923

8. AGE:

Years

Months

Days

If less than one day

17

8

16

hr.

min.

9. Birthplace

Portsmouth, Virginia

(Town, county, and state)

10. Usual Occupation

Tiggers Helper

11. Industry or business

FATHER

12. Name

Wm. M. Wright

13. Birthplace

Portsmouth, Va

MOTHER

14. Maiden Name

Amelia Robinson

15. Birthplace

Macon, N.C.

16 (a) Informant

James N. Wright

(b) Address

953 Glasgow St Portsmouth

17 (a)

Burial

(b) Date thereof

'9-3-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olive cem

Location

Portsmouth, Va

18 (a) Funeral director

Byron Wright

(b)

Portsmouth, Va

19 (a)

SEP 1 22 1943

(b)

Portsmouth, Va

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1943, at 2:20 M

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-29-43 at 2 a M

(b) Where did injury occur? 900 Park Ave

(c) Did injury occur at home, on farm, industrial place, in public

place?

public

While at work? no

(d) Means of injury

Revolver during altercation

23. Signature

J. L. Wallenweber M.D.

Date signed

8-29-43

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 82240 9

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood + Bryant*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *6 days*

3 (a) FULL NAME

Charles Valentine Wautz

3 (b) If veteran, name war

X

3 (c) Social Security Account

No. *none*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

58

hr.

min.

9. Birthplace

Wd. Westminister,
(Town, county, and state)

10. Usual Occupation

Auditor

11. Industry or business

FATHER
MOTHER

12. Name

Charles Valentine Wautz

13. Birthplace

Fred Co. Md.

14. Maiden Name

Caroline Pearce

15. Birthplace

Fred Co. Md.

16 (a) Informant

Mr. J. Pierre Smith

(b) Address

Westminister Md.

17 (a)

West Bernal

(b) Date thereof

Sept 4 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Westminister Cem.

Location *Westminister*

18 (a) Funeral director

J. E. Myers, Jr.

(b) Address

Westminister Md.

SEP 2 - 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(d) State *Md.*

(b) County *Anne Arundel*

(c) City or town

Blair Park

(If outside city or town limits, write RURAL and give town)

(d) Street No. *213*

1st. Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 1, 1943, at 10:40 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *7-26 1943* to *9-1 1943*, and that I last saw him alive on *9-1 1943*.

Immediate cause of death

*Repeated Spasms
Stomach*

Due to

Banta's Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: *Esophageal Varices; Splenomegaly*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. H. Lutz

Address *University Hospital*

Date signed *9/2/43*

G 07774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07774

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day

(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 2 - 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1943 to 9/1 1943 and that I last saw her alive on 9/1 1943.

Immediate cause of death

Biliary peritonitis

Due to

Due to

Other Conditions

C. partial intestinal obstruction

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07775
JL - 71965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07775
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **4940 Eastern Ave.**

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) **1-6-22**

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2 (a) FULL NAME

Harry Howard German

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 30, 1869

8. AGE:

Years **74**

Months **1**

Days **1**

If less than one day

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER

12. Name

Wm. Henry

13. Birthplace

Md.

MOTHER

14. Maiden Name

Mary Elizabeth Mullen

15. Birthplace

Md.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a)

Burial

(b) Date thereof

9/3/43

(c) Cemetery or crematory

Baltimore

Location **Balti. City**

18 (a) Funeral director

W. H. Cook, Inc.

(b) Address

Balti. City

19 (a)

SEP 8 - 1943

Huntington

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **1108 E. Pratt St.**

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/31

1943, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from **7/1 1943** to **9/31 1943** and that I last saw him alive on **9/31 1943**

Immediate cause of death

Myocardial infarction
coronary atherosclerosis

Due to

Due to

Other Conditions

Pass. pneumonia
septicemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

no post

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Seymour

Address

B. C. H.

Date signed

9/11/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS

G 07776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07776

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 630 Wyanoke Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William H. Gale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Emma Gale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1865

8. AGE: Years Months Days If less than one day

78

8

6

hr.

min.

9. Birthplace

Quantico Md

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Levin T. Gale

13. Birthplace

Quantico Md

14. Maiden Name

Virginia Rider

15. Birthplace

Md

16 (a) Informant

Emma Gale

(b) Address

Hawthorne Md

17 (a) Removal

(b) Date thereof 9/5/43

(Specify date of removal)

(month) (day) (year)

(c) Cemetery or crematory

Quantico

Location

Md

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul

19 (a)

SEP 8 - 1943

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1943, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1943, to 8/31 1943, and that I last saw him alive on 8/31 1943.

Immediate cause of death Cancer

Due to bilious cirrhosis

Due to cholelithiasis

Other Conditions sub-phrenic abscess; atelectasis of lower right lung.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: bilious cirrhosis, cholelithiasis, sub-phrenic abscess

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature H. Cohen

Address University Hospital Date signed 8/31/43

Duration

Jaundice
intermittent
liver 10g

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Caution: With this form, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07777

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2102 Bond St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary E Stein

3 (b) If veteran, name war

3 (c) Social Security Account

No. NONE

4 Sex

5. Color or race

6 (a) Single, married, widowed, or

Female

White

Married

6 (b) Name of husband or wife

John Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 26, 1871

8. AGE: Years Months Days

If less than one day

42

5

5

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Seagr. Gregory

13. Birthplace

Md.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Md.

16 (a) Informant

John Stein

(b) Address

2102 Bond St

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

Sept 1, 1943

(c) Cemetery or crematorium

Baltimore

Location

Baltimore, Md

18 (a) Funeral director

William Miller

(b) Address

1217 St Paul St

19 (a)

(Date rec'd by registrar)

(b)

William Miller

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2102 Bond St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1

1943, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1943 to 9-1 1943, and that I last saw him alive on 9-1 1943.

Immediate cause of death

Myocardial Regurgitation

Duration

4 years

Due to

Due to

Other Conditions

Myocardial Regurgitation & Water

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature David Miller

Address 1500 N Bond St

Date signed 9/1/43

SEP 2 1943

G 07778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07778

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

5. Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1943, to Aug. 31, 1943, and that I last saw him alive on Aug. 31, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Signed 9/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 6 1943

Huntington, Md.

G 07779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07779

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 651 W. Mulberry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 29/4

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-1891

8. AGE: Years 51 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

12. Name Henry Hill

13. Birthplace D. C.

14. Maiden Name Catherine?

15. Birthplace D. C.

16 (a) Informant Madeline Inman Taylor

(b) Address 703 Corn Court

17 (a) Burial (b) Date thereof 9-4-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Mt. Auburn

18 (a) Funeral director William A. Jackson

(b) Address 916 Penn. Ave.

SEP 2-1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 651 W. Mulberry St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1943 at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1943 to May 29 43 and that I last saw him live on May 29 43

Immediate cause of death

Carcinoma of uterus 1 yr

Duration

Due to

Due to

Other Conditions Hypertension 1 yr

Cardio Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Atwell Jones

Address 5514 Golfer St Date signed 9-1-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07780

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: 28-1
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mrs. Anna Josephine Prendergast
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1863

8. AGE: Years 79 Months 10 Days 29 If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Arthur O'Neill

13. Birthplace Ireland

14. Maiden Name Anna Brennan

15. Birthplace Ireland

16 (a) Informant Mr. Michael F. Prendergast

(b) Address 4111 Walrad Ave., Irvington

17 (a) Burial (b) Date thereof 9/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 SEP 2 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1943, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1943, to Sept. 1 1943, and that I last saw him alive on Sept. 1 1943.

Immediate cause of death
Cardio-Respiratory Failure

Due to Severe pneumonia, hepatic damage, and common duct, diagnosed still alive

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Aug. 27 1943
Major findings of operation: Salpingitis, Salt Bladder, Stone in Common Duct
of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. R. Engler

Address Mercy Hospital Date signed 9/1/43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07781
MS-77088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1365 N. Calhoun St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Stephen Dent

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Married-Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 7, 1868

8. AGE: Years

75

Months

3

Days

23

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
MOTHER

12. Name Stephen Dent

13. Birthplace Maryland

14. Maiden Name Jane Hanson

15. Birthplace Maryland

16 (a) Informant Rosie Dent

(b) Address 1434 Presatman St

17 (a) Burial

(b) Date thereof

9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

M. Calvary

Location Come Runn Co.

18 (a) Funeral director Mrs. Frances Hendry

(b) Address 578 W. Biddle St.

19 (a)

SEP 8 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/30

1943

4:00 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 7/1 1943 to 7/30 1943.

and that I last saw him alive on 7/30 1943.

Immediate cause of death

Bilateral

bronchopneumonia

Duration

3-4 d.

Due to

Due to

Other Conditions

Her. arterio-

sclerosis, mod.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

As above

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

E. L. Surpman

Address

16 C St

Date signed

M. D.

9/1

G 07782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07782

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 114 W. Saratoga St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore(c) City or town
(If outside city or town limits, write RURAL and give town)(d) Street No. 114 W. Saratoga St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph F. Mendelis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Elisabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
70 hr. min.9. Birthplace Lithuania
(Town, county, and state)10. Usual Occupation None

11. Industry or business

12. Name Peter Mendelis13. Birthplace Lithuania14. Maiden Name Mary Caplinskas15. Birthplace Lithuania16 (a) Informant Rev. Louis J. Mar delis(b) Address 114 W. Saratoga St.17 (a) Burial (b) Date thereof Sept. 2, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy RedeemerLocation Belair Road18 (a) Funeral director Joseph Kapuskas Inc(b) Address 6072 Black Bluff19 (a) SEP 2 - 1943 (b) Huntington, W. Va.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1943 5 PM21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1942 to Aug 30 1943, and that I last saw him alive on Aug 30 1943.

Immediate cause of death

STATIONARY BRONCHITIS
CHRONIC RESPIRATORY DISEASE
Due to ARTERIOSCLEROSISDuration
3 DAYS

Due to

Other Conditions BRONCHITIS1942

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following: NO

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Edward J. Wilson M.D.Address 1821 W. 5th St. Bk Date signed 9-1-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Chas. Weller
Park Heights 1943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07783
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3504 Oakmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Oakmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

J. Irving F. Barnes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Katherine Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-13-1865
8. AGE: Years 78 Months 6 Days 10 If less than one day hr. min.

9. Birthplace Parkersburg N.Y. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

12. Name William Barnes
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Dorothea Bowersox
(b) Address 3504 Oakmont Ave
17 (a) Burial (b) Date thereof Aug 30-43 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Marie Cook Snyder
(b) Address 1600 West North Ave

19 (a) SEP 2-1943 Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1943, at 2 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1943 to Aug 27 1943, and that I last saw him alive on Aug 26 1943.

Immediate cause of death

Due to Gangrene both feet
Due to Scurvy

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Charles J. Miller
Address 576 Park Heights Date signed Aug 30 1943

Duration

3 days

PHYSICIAN

Underline the name to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07784

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Say Ch Balpo for C. Hosp.*

(c) Hospital or institution:

1213 Light Street

(d) Length of stay in hospital or inst. (yrs., mos., or days) *15 min.*

(e) Length of stay in Baltimore (yrs., mos., or days) *nine months*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County *A. & C.*

(c) City or town

Fairfield

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Wilma KOFESKEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) ☒ Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 26 - 43*

8. AGE: Years Months Days If less than one day
5 5 hr. min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *Joseph Kofeskey*

13. Birthplace *Balto Co.*

MOTHER

14. Maiden Name *Evelyn Glover*

15. Birthplace *Baltimore*

16 (a) Informant *Parents*

(b) Address *Fairfield Md.*

17 (a) *Burial* (b) Date thereof *Sept 2 - 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Cornel*

Location *O'Donnell St*

18 (a) Funeral director *Thos. B. Connolly*

(b) Address *418 Boston Ave. Essex*

19 (a) *SEP 8 - 1943* H. *Washington, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 31 1943* at *11:50 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 2 1943* to *Aug 31 1943*, and that I last saw her alive on *Aug 31 1943*.

Immediate cause of death

Acute gastric ulceration

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Paul A. Gubato*

Address *1213 Light St.* Date signed *9/1/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07785

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital 4-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

3 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town

Chase, Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Ebenzer Road

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Wm B. Carback

(William B. CARBACK)

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 717-07-5259

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mabel F. Carback

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 14th 1874

8. AGE: Years

69

Months

0

Days

17

If less than one day

hr.

min.

9. Birthplace Baltimore Co. Maryland

(Town, county, and state)

10. Usual Occupation

Bridge Foreman

11. Industry or business

Railroad

FATHER

12. Name

William J. Carback

13. Birthplace

Baltimore Co. Maryland

MOTHER

14. Maiden Name

Frances R. Sterling

15. Birthplace

Baltimore Co. Maryland

16 (a) Informant

Mrs Wm B. Carback

(b) Address

Ebenzer Road Chase Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 3 1943

(c) Cemetery or crematory

Ebenzer Methodist

Location Chase, Maryland

18 (a) Funeral director

Lessons Funeral Home

(b) Address

7401 Belair Road

19 (a)

(b)

Huntington Williams, Md.

20. DATE OF DEATH

9/1/43

19

at

2¹²

M

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/1/43

19

at

2¹²

M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1943 to 9/1 1943

and that I last saw him alive on 9/1 1943

Immediate cause of death

Due to

Generalized Peritonitis

Due to

Ruptured gangrenous Appendix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8/30/43

Major findings of operations:

Same as above

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

(f) Address

(g) Date signed

(h) Signature

(i) Date of occurrence

(j) Where did injury occur?

(k) Did injury occur about home, on farm, industrial place, in public place?

(l) Means of injury

(m) Address

(n) Date signed

(o) Signature

(p) Date of occurrence

(q) Where did injury occur?

(r) Did injury occur about home, on farm, industrial place, in public place?

(s) Means of injury

(t) Address

(u) Date signed

(v) Signature

(w) Date of occurrence

(x) Where did injury occur?

(y) Did injury occur about home, on farm, industrial place, in public place?

(z) Means of injury

(aa) Address

(ab) Date signed

(ac) Signature

(ad) Date of occurrence

(ae) Where did injury occur?

(af) Did injury occur about home, on farm, industrial place, in public place?

(ag) Means of injury

(ah) Address

(ai) Date signed

(aj) Signature

(ak) Date of occurrence

(al) Where did injury occur?

(am) Did injury occur about home, on farm, industrial place, in public place?

(an) Means of injury

(ao) Address

(ap) Date signed

(aq) Signature

(ar) Date of occurrence

(as) Where did injury occur?

(at) Did injury occur about home, on farm, industrial place, in public place?

(au) Means of injury

(av) Address

(aw) Date signed

(ax) Signature

(ay) Date of occurrence

(az) Where did injury occur?

(ba) Did injury occur about home, on farm, industrial place, in public place?

(bb) Means of injury

(bc) Address

(bd) Date signed

(be) Signature

(bf) Date of occurrence

(bg) Where did injury occur?

(bh) Did injury occur about home, on farm, industrial place, in public place?

(bi) Means of injury

(bj) Address

(bk) Date signed

(bl) Signature

(bm) Date of occurrence

(bn) Where did injury occur?

(bo) Did injury occur about home, on farm, industrial place, in public place?

(bp) Means of injury

(bq) Address

(br) Date signed

(bs) Signature

(bt) Date of occurrence

(bu) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

(bv) Address

(bv) Date signed

(bv) Signature

(bv) Date of occurrence

(bv) Where did injury occur?

(bv) Did injury occur about home, on farm, industrial place, in public place?

(bv) Means of injury

G 07786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164C

G 07786

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4707 Gunther Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 4707 Gunther Ave.(e) Citizen of foreign country? NO (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME

Howard Mumma

(HOWARD, S. MUMMA)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 18948. AGE: Years Months Days If less than one day
59 2 9 hr. min.9. Birthplace Baltimore Co. Maryland
(Town, county, and state)10. Usual Occupation Watchman11. Industry or business Bank12. Name George S. Mumma13. Birthplace Baltimore Co. Maryland14. Maiden Name Letitia Erdman15. Birthplace Baltimore Co. Maryland16 (a) Informant Mrs. Vernon E. Gentry(b) Address 4709 Gunther Ave.17 (a) Burial (b) Date thereof Sept. 3 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory David Ridge
Location Baltimore Md.18 (a) Funeral director Essam General Home(b) Address 7401 Belair Road19 (a) SEP 8 - 1943 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-1943 at 9 A M21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Shot gun of chest

Due to

Other Conditions Dependent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9/1/43 at 8:40 A M(b) Where did injury occur? 4707 Gunther Ave.(c) Did injury occur at home, on farm, industrial place, in public
place? Home While at work? no(d) Means of injury Self inflicted shotgun wound.23. Signature Howard J. Mumma M.D.Date signed 9/1/43

Medical Examiner.

G 07787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07787
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3213 S. Baltimore St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3213 S. Baltimore St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Frederick John Marty

3 (b) If veteran, name war

3 (c) Social Security Account
No. 216-10-3463

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Anna M. O. Marty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 - 1872

8. AGE: Years 71 Months 1 Days 23
If less than one day hr. min.9. Birthplace New York Germany
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business Linn's Hospital

12. Name Nicholas Marty

13. Birthplace Germany

14. Maiden Name Sophia

15. Birthplace Germany

16 (a) Informant Mrs. Anna M. O. Marty

(b) Address 3213 S. Baltimore St

17 (a) Burial (b) Date thereof Sept 3/44
(Place of interment, or removal) (Month) (day) (year)

(c) Cemetery or crematory Oak Grove

Location Baltimore

18 (a) Funeral director Philip Henry and

(b) Address 2434 Calver St

19 (a) SEP 2 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1943 at 4:30 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtainedby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Horst J. Walden M.D.

Date signed 9/1/43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07788

G 07788
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 19-2
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
109 N. Bruce St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Silva

83166

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex male 5. Color or race black 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mrs. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1906

8. AGE: Years 36 Months 11 Days 9 If less than one day hr. min.

9. Birthplace Cape Verdi Islands
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Silva
13. Birthplace Cape Verdi Islands
MOTHER 14. Maiden Name Caroline Footz
15. Birthplace Cape Verdi Islands

16 (a) Informant Hospital records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 4, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3229 Schroeder St

19 SEP 2 - 1943 State Rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1943 10:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11, 1943 to Sept. 1, 1943, and that I last saw him alive on Sept. 1, 1943.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Malt

Address B.C.H.

Date signed 9/1/43

Duration

1 yr?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07739

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

886 Tyson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Ida May Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Joshua Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 1898

8. AGE:

Years

Months

Days

If less than one day

45

7

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

12. Name

William H. Ridgley

13. Birthplace

Harford Co. Md.

14. Maiden Name

Mary Dennison

15. Birthplace

Baltimore Md.

16 (a) Informant

Daisy Taylor

(b) Address

886 Tyson St

17 (a) Burial

(b) Date thereof Sept. 2, 1943

(c) Cemetery or crematory

Mt. Auburn Cem

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Lombard St

SEP 2 - 1943

(Date rec'd by registrar)

Huntington Williams, Jr.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

886 Tyson St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 29

1943

at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1943, to Aug. 29, 1943, and that I last saw him live on Aug. 29, 1943.

Immediate cause of death

Congestive Heart Failure

Due to

Hypertension

Due to

Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ralph W. Reckling

Address

426 N. Gilmor St

Date signed 9/1/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 735 1/2 W. Mulberry Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN HENRY COPELAND

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. 218-01-5213

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary H. Copeland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1899

8. AGE:

Years

Months

Days

If less than one day

44

5

21

hr.

min.

9. Birthplace

Suffock, Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Copeland

13. Birthplace

Va.

MOTHER

14. Maiden Name Mary Porter

15. Birthplace

Va.

16 (a) Informant Mary H. Copeland

(b) Address

735 1/2 W. Mulberry St.

17 (a)

Burial

(b) Date thereof

Sept. 3, 1943

(Burial, cremation, or other method)

(c) Cemetery or crematorium

Suffock Va.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Richards St.

19

SEP 2 - 1943

Huntington Williams, Md.

MEDICAL CERTIFICATION 3 A.

20. DATE OF DEATH August 31, 1943, at M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Tuberculosis, pulmonary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.

Medical Examiner.

Date signed 8-31-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07791

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 157 Palormo Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

3 (a) FULL NAME

CALVIN F. TREGO.

3 (b) If veteran, name war

3 (c) Social Security Account
No. 215-10-2948

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married.

6 (b) Name of husband or wife Tillie S. Trego.

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) March 29 - 1888

8. AGE:

54 Years

Months

5

Days

8

If less than one day

hr.

min.

9. Birthplace Washington - D.C.

(Town, county, and state)

10. Usual Occupation Milk Salesman

11. Industry or business W. Md. Dairy

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Ellen Talbot

15. Birthplace Washington - D.C.

16 (a) Informant Mr. Edwin J. Trego

(b) Address 201 S. Hilton St.

17 (a) Burial (b) Date thereof Sept. 3 - 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Louisa Park Cem.

Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwalb

(b) Address 505 N. Monmouth St.

19 (a) 201 S. Hilton St.

(b) Baltimore - Md.

20 (a) 201 S. Hilton St.

(b) Baltimore - Md.

21 (a) 201 S. Hilton St.

(b) Baltimore - Md.

22 (a) 201 S. Hilton St.

(b) Baltimore - Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 157 Palormo Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 - 1943 at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Aug 31 1943, and that I last saw him alive on Aug 31 1943.

Immediate cause of death

Coronary Thrombosis

Due to Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edwin J. Trego

Address 201 S. Hilton St.

Baltimore - Md.

201 S. Hilton St.

Baltimore - Md.

Duration

2 days

2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

(over)

G 07792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07792

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *none*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1115 E. Baltimore St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LILLIAN

BRIGGERMAN

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. *none*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 4, 1885*8. AGE: Years *68* Months *27* Days *1* hr. min.9. Birthplace *Atlanta Ga*
(Town, county, and state)10. Usual Occupation *Housewife*

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *James J. Magge*
(b) Address *1115 E. Baltimore St*17 (a) *Funeral* (b) Date thereof *9/2/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *St. John's*
Location *Baltimore Md*18 (a) Funeral director *William J. Mc*(b) Address *1219 E. Bond St*19 *SEP 2 1943* (b) *Huntington*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 1st 1943* at *3:50 PM*21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *her* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive cardiovascular
Due to *disease*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature *H. J. Wollenweber* M.D.Date signed *9-2-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67793

COMOR
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46m

G-07793
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

- William G. Cumor
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced M

- 6 (b) Name of husband or wife Mrs. Wm. G. Cumor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1866

8. AGE: Years 76 Months 11 Days 28 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

- FATHER 12. Name John T. Cumor

13. Birthplace

- MOTHER 14. Maiden Name Aliza Guss

15. Birthplace Maryland

- 16 (a) Informant Mrs. Myrtle H. Cumor

- (b) Address 3241 Chestnut Ave.

- 17 (a) Burial (b) Date thereof Sept. 3, 1943
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or place of interment Harland Memorial Pk.

- Location Parkville, Balt. Co., Md.

- 18 (a) Funeral director Frank J. Sarty

- Address 846 N. 36 St.

- 19 (a) SEP 2 1943

- (Date rec'd by registrar) William G. Cumor

- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1943, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1943, to Sept. 1, 1943, and that I last saw him alive on Aug. 31, 1943.

- Immediate cause of death Cancer - respiratory failure

- Due to Gastro-intestinal hemorrhage 1 yr. (?)

- Due to Gastro-intestinal malignancy

- Other Conditions hemiplegia

- (Include pregnancy within 3 months of death)

- Date of operation

- Major findings of operations

- of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

- (Specify type of place)

- (e) Means of injury

23. Signature George W. Muzzaterra Jr.

- Address 332 E. University Physician signed 9/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

177840342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07794
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 405 N. Calver St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Elizabeth Clark

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female Black

5. Color or race

6 (a) Single, married, widowed, or divorced

Mar.

6 (b) Name of husband or wife

Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-15-1904

8. AGE:

Years

Months

Days

If less than one day

41315

hr.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

12. Name

Charles Clark

13. Birthplace

MD.

14. Maiden Name

Rachael

15. Birthplace

MD.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 2, 1945

(c) Cemetery or crematory

MT Calvary

Location

18 (a) Funeral director

Chas. Wilson

(b) Address

1000 Broadway

SEP 2 1945

(b) Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945 at 4:50 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28, 1945 to Aug 30, 1945 and that I last saw him alive on Aug 30, 1945.Immediate cause of death hypertensive arteriosclerotic C-V disease & failure

Duration

Due to

Due to

Other Conditions senile cataractsst. eye proptosis; latent syphilis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John R. Birmingham

Address

J.H.H.Date signed 8-30

FURNISH WRITING MATERIAL, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07795

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6420 Rustertown Road

(c) Hospital or institution:

Mount Hope Retical

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Clinton Delahay Robertson Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 13 1890

8. AGE:

Years

Months

Days

53118

If less than one day

hr.

min.

9. Birthplace

Oxford Md

(Town, county, and state)

10. Usual Occupation

Railroad Conductor

11. Industry or business

12. Name Franklin Clinton Robertson

13. Birthplace

Oxford, Md14. Maiden Name Margaret Jane Delahay

15. Birthplace

Oxford Md

16 (a) Informant

Mount Hope Retical

(b) Address

6420 Rustertown Road

17 (a)

Burial

(b) Date thereof

9/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oxford

Location

Oxford, Md

18 (a) Funeral director

Colonial Funeral Home

(b) Address

900 Calverton Place

(c) City

Huntington Hills, Md

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Delaware (b) County(c) City or town Clayton

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1943 at 11:15 AM21. I certify that death occurred on the date above stated; that I attended deceased from July 21, 1943 to September 14, 1943 and that I last saw him alive on Sept 14, 1943.Immediate cause of death Virus Borna

Duration

3 days

Due to

Due to

Other Conditions Psychosis with hypertension and arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

33 W. 1st St. Clay

M. D.

07796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07796

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St

(c) Hospital or institution: Penn Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(d) Street No 2525 W. Balto St

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No 212-05-4140

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife

Mr. Sadie Tracy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/24/96

8. AGE:

Years

47

Months

11

Days

1

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Powerhouse Operator

11. Industry or business

Gas & Electric Co

FATHER

12. Name

Charles Tracy

13. Birthplace

Balto Md

MOTHER

14. Maiden Name

Mary E. Doyle

15. Birthplace

Balto Md

16 (a) Informant

Mrs Chas. E. Tracy

(b) Address

2525 W. Balto St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9/3/43

(c) Cemetery or crematory

Balto National

Location

Bridgelyck Rd

18 (a) Funeral director

J. H. K. K. K.

(b) Address

1600 Hollins St

SEP 2 1943

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/31

1943

at 6

A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1943 to 8/31 1943, and that I last saw him alive on 8/31 1943.

Immediate cause of death

Cerebral metastases.

Duration

Due to

Broncogenic carcinoma left lung

Due to

Other Conditions

Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward L. K. K. K.

Address

Penn Secours Hosp

Date signed

8/31/43

07797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07797
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Linden & Madison*

(c) Hospital or institution:

Med. Gen. Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 1/2 days*(e) Length of stay in Baltimore (yrs., mos., or days) *Same*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *A. A. Co.*(c) City or town *Brooklyn PK, MD*
(If outside city or town limits, write RURAL and give town)(d) Street No. *107 14th Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Girl Berg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 18, 1943*8. AGE: Years Months Days
0 0 14 1/2 hr. min.9. Birthplace *Baltimore, Maryland*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Franklin G. Berg*13. Birthplace *Baltimore Md.*14. Maiden Name *Boulah Ginkel*15. Birthplace *Baltimore, Md.*16 (a) Informant *mother*(b) Address *107 14th St.*17 (a) *Burial* (b) Date thereof *Sept 3, 43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or *Glen Haven*
Location *Glen Haven, Md.*18 (a) Funeral director *Milton Schilling*(b) *SEP 8 1943 S. Hagerman St**SEP 8 - 1943* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-1-1943* at *10 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *8-18 1943* to *9-1-1943*, and that I last saw her alive on *9-1-1943*.

Immediate cause of death

Unknown

Due to

(initials)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *None*

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *William G. Mitchell*Address *Med. Gen. Hosp.* Date signed *9/1/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

07798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07798
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 343 FONTHILL AVENUE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 343 FONTHILL AVENUE.

(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

WILLIAM R. THOMAS

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

CARRIE M. THOMAS6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

FEB-23-1885

8. AGE:

Years

58

Months

6

Days

9

If less than one day

hr.

min.

9. Birthplace

BALTIMORE, MD.

(Town, county, and state)

10. Usual Occupation

RETIRED

11. Industry or business

BLUE MFG.

FATHER

12. Name

LOUIS THOMAS

13. Birthplace

BALTIMORE

MOTHER

14. Maiden Name

IDA DITMAN

15. Birthplace

BALTIMORE

16 (a) Informant

CARRIE M. THOMAS

(b) Address

343 FONTHILL AVENUE.

17 (a)

BURIAL

(b) Date thereof

SEPT 4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

MOUNT OLIVET

Location

F&E

18 (a) Funeral director

C. RAYMOND KAUFMAN

(b) Address

1026 LEEDS AVENUE

19

SEP 2 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1943, at 9:00 AM21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1943 to Aug 31 1943 and that I last saw him alive on Aug 31 1943

Immediate cause of death

Coronary failure.

Duration

Due to

Thrombotic Coronary P-9412

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence +

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. B. Williamson

Address

2151 Wilkins Ave

Date signed

9/2/43

Physicians write plainly, with UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07799

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Bellona Ave.

(c) Hospital or institution: Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 24 Wheeler Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena E. Shilling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Geo. H. Shilling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1860

8. AGE: Years 83 Months 8 Days 11 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Herbert Shilling

(b) Address 24 Wheeler Ave.

17 (a) Burial (b) Date thereof Sept 4 - 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Fern
Location Woodlawn Md.

18 (a) Funeral director Loring Byers

(b) Address 5005 Park Heights

SEP 2 - 1943 (Date of death) H. H. Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1943 at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1943 to Aug 31 1943, and that I last saw her alive on Aug 31 1943.

Immediate cause of death Cerebral Hemorrhage

Due to Atherosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dr. Walter Spunner MD

Address 3643 Edmondson Date signed 9/1/43

Duration 1 1/2 mos.

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

87800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 87800
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mo., or days) 21 days
(e) Length of stay in Baltimore (yrs., mo., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:

- (a) State Pa. (b) County _____
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 W. Clearfield St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME

ERWIN MEYER

3 (b) If veteran, name war

3 (c) Social Security Account
No. _____

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 27, 1886

8. AGE: Years Months Days If less than one day
58 3 3 hr. min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Captain

11. Industry or business Barge Oneida (Gulf Oil Co.)

12. Name Erwin Meyer

13. Birthplace Germany

14. Maiden Name Adellia Meyer

15. Birthplace GERMANY

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) BURIAL (b) Date thereof 9-4-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium
Location Philadelphia Pa

18 (a) Funeral director W. L. Odes

(b) Address 4644 Park Rd. Williams, Md.

19 SEP 2-1943

Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 30, 1943 at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1943 to Aug. 30, 1943, and that I last saw him alive on Aug. 30, 1943.

Immediate cause of death
Coronary thrombosis

Due to Arteriosclerotic heart disease

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: _____

of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
While at work? _____
(Specify type of place)

(e) Means of injury _____

Signature Caum

Address Baltimore, Md.

Date signed 8/31/43

Duration
Immed.
prior to
death

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07801
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days

If less than one day

14 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Clarence Edward Sullivan

13. Birthplace

MOTHER

14. Maiden Name Emma Frien

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof 9/3/43

(Burial, cremation, or removal)

(c) Cemetery or crematory St Peters

Location Balto. Md.

18 (a) Funeral director

(b) Address

SEP 27 1943

VS 140

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10:45 A.M. to 6:45 P.M.

and that I last saw him alive on Sept. 1, 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9-1-43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07802

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *002*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *6 S. Charles St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HARRY Socket

3 (b) If veteran, name war

3 (c) Social Security Account

No. *220-07-8861*

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 15, 1883*8. AGE: Years Months Days If less than one day
60 3 16 hr. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

*Tailor*FATHER
MOTHER12. Name *Morris Socket*13. Birthplace *Russia*14. Maiden Name *Anna Silverman*15. Birthplace *Russia*16 (a) Informant *Mrs Bertha Alter*(b) Address *2018 E Baltimore St*17 (a) *Burial* (b) Date thereof *Sept. 3, 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Hebrew Mt Carmel Cen*
Location *German Hill Road*18 (a) Funeral director *Sol Levinson & Bros*(b) Address *1124 1126 W North Ave*19 *SEP 2 - 1943* (b) *Huntington Williams, M.D.*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 1st 1943, at 10:20 PM*21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hyperostosis of prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature *W. J. Williams, M.D.*
Medical ExaminerDate signed *9-2-43*

07803 H. P. Co.—1900 Eds.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 07803

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Registers town Rd

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Phillips

WARD 15-5

(a) RESIDENCE. No.

2904 Registers town Rd

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos.

How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

6a If married, widowed, or divorced, HUSBAND or (or) WIFE of Jacob Phillips

6 DATE OF BIRTH (month, day, and year)

Oct 26/1876

7 AGE

Years 66

Months 10

Days 6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York City

10 NAME OF FATHER

Abraham Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Hannah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Harry Phillips (son) 2904 Registers town Rd

15

SEP 2-1943

Huntington Williams

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 1 1943

17

I HEREBY CERTIFY, That I attended deceased from for about 3 years.

that I last saw him alive on Sept 1 1943

and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(over)

CONTRIBUTORY (Secondary)

Carcinoma

(duration) yrs. 5 mos. da.

(duration) 2 yrs. 6 mos. da.

18 Where was disease contracted? If not at place of death?

Did an operation precede death?

Yes Date of 2 1/2 years ago

Was there an autopsy?

No

What test confirmed diagnosis?

Usual

(Signed)

B. M. Bernstein M. D.

9/1/43

Address 3455 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Felt row Washington Rd

Sept 3 1943

20 UNDERTAKER

Joh. L. Wilson & Bros

ADDRESS 1126

W. North ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07804
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ma (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 209 N. Gilmore St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Booker T. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1915

8. AGE: Years Months Days If less than one day

28 6 17 hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Wallace Jackson

13. Birthplace S. C.

14. Maiden Name H. Higgins

15. Birthplace S. C.

16 (a) Informant Emma Higgins

(b) Address 1111 N. Carey St

17 (a) Burial (b) Date thereof 8/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory mt. Calvary

Location md

18 (a) Funeral director Wesley H. Kelson

(b) Address 1303 Pressman

19 (a) (b)

(Date rec'd by registrar)

SEP 3-1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1943, at 11:30 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1943 to Aug 30 1943, and that I last saw him alive on Aug 30 1943.

Immediate cause of death

Tuberculous Pneumonia

Due to

Due to

Other Conditions Pulmonary T.B.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. B. Banfield

Address Provident Hospital Date signed 8-31-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07805

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3812 Juniper Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph G. Kuhn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife 10 - r - 1889

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 2 - 1889

8. AGE: Years Months Days If less than one day

53 10 29 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Account Corp. V. President

11. Industry or business

12. Name George E. Kuhn

13. Birthplace Baltimore

14. Maiden Name Mary Mueller

15. Birthplace md

16 (a) Informant Henrietta Kuhn

(b) Address 3812 Juniper Road

17 (a) Burial (b) Date thereof 9 - 3 - 43.

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic

Location

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 SEP 3 - 1943

(Date ruled by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County 12 - 1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Juniper Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 31 - 1943 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1942, to Aug 31 1943, and that I last saw him alive on Aug 30 1943.

Immediate cause of death

Periarteritis nodosa
Associated bilateral upper &
lower extremity paralysis

Duration 8 months

Due to

Other Conditions Essential hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. V. Harbold M.D.

Address 4706 Harford Road Date signed 9/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

De Registrar
1402 E. Lombard St.
Registered No. 07806

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1236 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County 9-9
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Annie Louie Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

John R. Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 30 1887

8. AGE:

Years

Months

Days

less than one day

63

11

1

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

12. Name John Roeder

13. Birthplace Germany

14. Maiden Name Katherine Thomas

15. Birthplace Germany

16 (a) Informant John Myers

(b) Address 1236 E. Lafayette Ave.

17 (a) Burial (b) Date thereof 9-3-43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Balto md

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

19 (a) SEP 3 - 1943
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1943 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1943 to Aug 31 1943, and that I last saw her alive on Aug 26 1943

Immediate cause of death

Rheumatic C.V. disease
Arterio sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. Granger
Address 1402 E. Lombard St. Date signed 9-3-43

Duration

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07807

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07807

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3025 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County 12-2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

MARGARET BAILEY

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife Frederick Julien Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/20/1865

8. AGE: Years

77

Months

10

Days

11

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Charles A. Mitchell

13. Birthplace Cambridge, Md.

14. Maiden Name Margaret Roach

15. Birthplace Accomac Co., Va.

16 (a) Informant Mrs. Dorothy B. LeCompte

(b) Address St. Michaels, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/3/1943

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cem.

Location

Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 19 43 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 23 1942 to Sept 1 1943.

and that I last saw him alive on Sept 1 1943.

Immediate cause of death

Mitral insufficiency and aortitis

Due to Rheumatic fever when a child

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John A. Lutscher
E. Egger II - Date signed Sept 2/43

Duration

Since age 8

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 9-1943

07808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07808

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 2803 Garrison Blvd.
- (c) Hospital or institution:
Garrison Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1728 Darley Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY PRISCILLA GOUGH

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife William Vernon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1881

8. AGE: Years

62

Months

6

Days

4

If less than one day

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

MOTHER

12. Name George Washington Neilson

13. Birthplace Balto., Md.

14. Maiden Name Elizabeth Green

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William Vernon Gough

(b) Address 1728 Darley Ave.

17 (a) Burial (b) Date thereof 9/3/43

(Final, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (b)

(Date rec'd by registrar)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13, 1943, to Aug 31, 1943, and that I last saw him alive on Aug 31, 1943.

Immediate cause of death

Acute Myocardial Infarction
Atherosclerosis

Due to

Myocardial Infarction
Disease

Other Conditions

Phlebotomy, lower leg

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

Duration

4 days

8 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

1520 E. 3rd St. Date signed 9/2/43

SEP 9 - 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 5004 Norwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County 28-2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

KATIE NILES BAILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Ambrose H. Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1871

8. AGE: Years 71 Months 10 Days 6 If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Caesar R. Niles

13. Birthplace Del.

14. Maiden Name Margaret Bailey

15. Birthplace Del.

16 (a) Informant Donald M. Niles

(b) Address 301 E. Wisteria Crest Rd.,
Wildwood, N. J.

17 (a) Burial (b) Date thereof 9/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) SEP 8 1943

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21, 1941 to Sept 1, 1943, and that I last saw her alive on Sept 1, 1943.

Immediate cause of death

1. Arterio Sclerosis
Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Earl L. Chamber

Address 410 E. Liberty St. Date signed 9/1/43

Duration

5 yrs?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PRINTED WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 A. Patt. PK. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1-5
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 A. Patt. PK. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Liba Miller
3 (b) If veteran, name war 3 (c) Social Security Account No. 213-12-6715

4. Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 45 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business
12. Name Michael Miller
13. Birthplace Russia
14. Maiden Name Esther
15. Birthplace Russia
16 (a) Informant Harry Miller (b) Address 216 A. Patt. PK. Ave
17 (a) Burial (b) Date thereof 9-3-43 (month) (day) (year)
(c) Cemetery or crematory Rosedale Location
18 (a) Funeral director Jace Heine Inc (b) Address 1439 B. Balto. St.
19 (a) Date rec'd by registrar (b) Huntington Williams, M.D. Registrar

20. DATE OF DEATH 9-2-43 1943 at 9:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1943 to 9/2 1943 and that I last saw her alive on 9/1 1943.
Immediate cause of death Metastatic growth of hyper Carcinoma of the Breast
Due to Carcinoma of the Breast
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature O. Henry Flor Address 3215 Eastern Ave Date signed 9/2/43

G 07811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07811

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date of birth)

1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Physicians with PAINLESS, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07812
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1309 Elmstead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County 25-5
(c) City or town Curtiss Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Elmstead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby ^{Edward} Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1943

8. AGE: Years Months Days less than one day

6 hr. min.

9. Birthplace Curtiss Bay
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

12. Name Robert Lee Jackson

13. Birthplace Houston, Tex.

14. Maiden Name Heleen T. Olip

15. Birthplace Baltimore

16 (a) Informant Robert Lee Jackson

(b) Address 1309 Elmstead

17 (a) Burial (b) Date thereof 9/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director William M. Marek

(b) Address 715 Light St

19 (a) SEP 3 - 1943 (b) William M. Marek

VB 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1943, at 11 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Sept 1 1943 to Sept 1 1943 and that I last saw him alive on Sept 1 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type or place)

(e) Means of injury

23. Signature Ray P. Dyer

Address 4700 Parkington

Date signed Sept 5/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07813

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1309 Elmstead St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby, Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 1, 1943*

8. AGE: Years Months Days

or less than one day

6 hr. min.9. Birthplace *Curtiss Bay*
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

*None*12. Name *Robert Lee Jackson*13. Birthplace *Johnstonson City, Tenn.*14. Maiden Name *Heleen J. Olup*15. Birthplace *Baltimore*16 (a) Informant *Robert Lee Jackson*(b) Address *1309 Elmstead St.*17 (a) *Burial* (b) Date thereof *9/3/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Glen Haven*Location *Glen Haven*18 (a) Funeral director *William M. March*(b) Address *715 E. 15th St.*19 (a) *SEP 3 - 1943*
(Date rec'd by registrar) *William M. March*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *25-5*(c) City or town *Curtiss Bay*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1309 Elmstead St.*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 1, 1943*, at *11 P.M.*21. I certify that death occurred on the date above stated, that I attended deceased from *Sept 1, 1943* to *Sept 1, 1943* and that I last saw him alive on *Sept 1, 1943*

Immediate cause of death

Preterm birth
6 1/2 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Robert Lee Jackson*Address *4700 Rawmeyer* Date signed *Sept 2, 1943*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07814

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 601 Mt. Holly St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Delia A. Crocken

DELIA AGNES CROCKEN

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife Nelson T. Crocken

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years Months Days If less than one day

66

6

30

hr.

min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Thomas Knight

13. Birthplace Ireland

14. Maiden Name

15. Birthplace Ireland

16 (a) Informant Mrs. Nora T. Wohler

(b) Address 601 Mt. Holly St.

17 (a) Burial (b) Date thereof 9/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto., Md.

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2004 8 Orleans St.

19 (a) SEP 3 - 1943

(Date rec'd by registrar)

Huntington Williams

20. DATE OF DEATH

9/1

1943, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1943, to 9-1 1943.

and that I last saw her alive on 9-1 1943.

Immediate cause of death

Purulent Illness

Duration

3 days

Direct Cause of Death Localized Peritonitis (Pelvic)

6 days

Due to

Diverculitis, acute perforating

Other Conditions

Hypertension arteriosclerotic

Date of operation 8-25-43

Major findings of operation:

Same

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Edward L. Knight

M. D.

Address Bon Secours Hospital

Signed 9-1-43

PLEASE WRITE FAINTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a G 07815
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31, 1943, to Sept 2, 1943, and that I last saw him alive on Sept 2, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

SEP 3 1943

H. H. Williams, M.D.

Address

Date signed

G 07817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07817

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

52 → 54

20

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

SEP 8 - 1943

Registrar

VB 151

MEDICAL CERTIFICATION

20. DATE OF DEATH

8 - 31 -

1943

at 11 P M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Shot gun 7 abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? Farm While at work? No

(d) Means of injury

23. Signature

Date signed

Medical Examiner

G 07818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07818
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) SEP 3 1943

19 (a) (b) (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

(If yes, name country)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Sept 1 1943, and that I last saw him alive on Aug 31 1943.

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

NEVER WRITE IN PENCIL. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE
FEDERAL WHITE PAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

440 2147819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07819
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John Fischer

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-03-9085

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

MARY

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.)

2-12-01

8. AGE:

Years

Months

Days

If less than one day

42

6

20

hr.

min.

9. Birthplace

Md

(Town, county and state)

10. Usual Occupation

PAPER PUNCHER

11. Industry or business

12. Name

PAUL C. FISCHER

13. Birthplace

GERMANY

14. Maiden Name

EMMA

15. Birthplace

U.S.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 4/43

(c) Cemetery or crematory

Cath Hill Cem.

Location

Hopkins

18 (a) Funeral director

John A. Miller

(b) Address

2334 Jefferson St.

19 (a)

(Date registered)

(b)

Sept 8 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

7-3

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2218 M^c ELDERRY

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1943. at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1943 to Sept 2 1943, and that I last saw him alive on Sept 2 1943.

Immediate cause of death

Cardiac failure

Due to

Aortic stenosis + insufficiency + subacute bacterial endocarditis

Due to

Congenital bicuspid aortic valve

Other Conditions

Mitral insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert Day

Address Johns Hopkins Hosp.

Date signed 8/2/43

Every item of information should be carefully and legibly written in ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

D.07820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. D.07820

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 724 N. Kenwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John William Reiblich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Alice (nee Feuchter)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/82

8. AGE: Years Months Days If less than one day
60 yrs. 9 3 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

12. Name George Reiblich

13. Birthplace Maryland

14. Maiden Name Elizabeth Schmidt

15. Birthplace Baltimore, Md.

16 (a) Informant Alice Reiblich (wife)

(b) Address 724 N. Kenwood Avenue

17 (a) Burial (b) Date thereof 9/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment Balto. Cemetery
Location North Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 SEP 9 1943

VS 14

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1943, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26/1943 to 8/31/1943, and that I last saw him alive on 8/31/1943.

Immediate cause of death

Coronary thrombosis

Due to

Coronary sclerosis

Due to

General atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury (Specify type of place)

23. Signature J. A. Barden

Address 1517 8 North Ave. Date signed 9/1/43

Duration

1 day

Sign

5/26/43

11

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07821
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Denison Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Race or place

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife Martha Todd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16-1866

8. AGE: Years 77 Months 15 Days 15 hr. min.

9. Birthplace Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

12. Name George Todd

13. Birthplace Maryland

14. Maiden Name Mays

15. Birthplace Maryland

16 (a) Informant Herbert Todd

(b) Address 2076 Rockrose Ave

17 (a) Burial (b) Date thereof Sept. 4-1943

(c) Cemetery or crematory St. Marys (Cathedral)

Location Baltimore, Md.

18 (a) Funeral director Burger Funeral Home

(b) Address 3631 Falls Road

19 (a) SEP 8 1943 (b) J. William

VS 144

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2076 Rockrose Ave

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1943, at 1:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Sept 1 1943, and that I last saw him alive on Sept 1 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertensive CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Lawrence J. Shumanek

Address 3711 Falls Rd

Date signed 9-5-43

Duration 1 mo.

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

SHUMANEK.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 07822

G 07822

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Betty Lee Rhodes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-34

8. AGE: Years 9 Months 7 Days — hr. min.

9. Birthplace Md - Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

12. Name Earl T. Rhodes

13. Birthplace Md

14. Maiden Name Charlotte Wilhide

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 3-1943 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory M. Mary's (d) Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 2631 Falls Road

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (Date rec'd by registrar) (Signature) (Address) (City) (State) (Zip)

SEP 3 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3600 Paine St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1943 at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Aug 30 1943, and that I last saw her alive on Aug 30 1943.

Immediate cause of death cardiac failure

Due to Endocarditis, myocarditis and pericarditis Rheumatic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Heku Bowie

Address Johns Hopkins Hosp Date signed 8/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07823

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 2 1943, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 4 1943 to SEP 2 1943 and that I last saw him alive on SEP 2 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

SEP 3 - 1943

07824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH186a ✓ G 07824
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3409 White Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3409 White Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Grace Kay Dudley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1869

8. AGE: Years Months Days If less than one day

73 76 10 21 hr. min.9. Birthplace Crestonville Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name William13. Birthplace Maryland14. Maiden Name unknown15. Birthplace unknown16 (a) Informant Grace Dudley(b) Address 3409 White Avenue17 (a) Burial (b) Date thereof 9-3-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location

18 (a) Funeral director Leonard J. Quirk(b) Address 5005 Parkside Drive23. Signature Horatius J. Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1943 at 4:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to August 1943and that I last saw him alive on Aug. 18 1943

Immediate cause of death

Fracture rt. femoral neck

Duration

2 MonthsDue to Pagets Disease BoneUnbroken

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-26-43

Major findings of operation:

Healing of fractured femoral neck

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident(b) Date of occurrence July 4 1943 at PM(c) Where did injury occur? Baltimore

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No(e) Means of injury Tripped in rug, pathological fracture23. Signature E. W. Peake

M. D.

Address 4505 Naylor Date signed

SEP 7 1943

VS 110

approved by Horatius J. Williams, M.D.

PLEASE WRITE FINGERPRINTS, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07825
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address 3718 10th St. Brooklyn

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3718 10th St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1873

8. AGE: Years Months Days If less than one day
70 2 25 4 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Self

12. Name George Holmes

13. Birthplace Baltimore, Md.

14. Maiden Name Elizabeth Fouts

15. Birthplace Baltimore, Md.

16 (a) Informant Irene Shoemaker

(b) Address 3718 10th St. Brooklyn

17 (a) Burial (b) Date thereof 9/6/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Cemetery
Location Milton & North Ave

18 (a) Funeral director Howard H. Blight Jr.

(b) Address 4944 Belair Road

19 (a) Date rec'd by registrar SEP 3-1943
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1943, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943, to 9/2 1943
and that I last saw him alive on 9/2 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

Due to Atherosclerosis

Other Conditions arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Samuel A. M. D.

Address 203 Calverton Date signed

07826

JL - 82929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07826

Registered No.

51B

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1936 Druid Hill Ave.

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

William E. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

O

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Eaton (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 12, 1876

8. AGE: Years Months Days

If less than one day

66

9

11

19

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

Old Age Pension

11. Industry or business

FATHER

12. Name

Flick

13. Birthplace

MD

MOTHER

14. Maiden Name

Magdaline Marshall

15. Birthplace

Va.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

9/13/43

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore City

18 (a) Funeral director

Mrs. Mary G. Hall

(b) Address

1631 Druid Hill Ave.

SEP 28 - 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1943 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1943 to 8/31 1943 and that I last saw him alive on 8/31 1943.

Immediate cause of death

Aortic & extensive
coronary atherosclerosis; myocardial infarction

Due to

Other Conditions

Aortic insufficiency

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. J. Surgen

Address

10 C H

Date signed

9/1

G 07827

2. USUAL RESIDENCE OF DECEASED:

(a) State 729. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 423 D. Chester St
(If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

Frances Gakens

3 (c) Social Security Account No. 1

6 (a) Single, married, widowed, or divorced. *single*

20. DATE OF DEATH Sep 1 1943, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1941 Sept. 1 1943 and that I last saw her alive on Sept. 1 1943.

Immediate cause of death: Asphyxiation

Myocardial Insufficiency 10 days.
Due to Chronic Myocarditis 3 yrs.

Due to _____

name

Other Conditions: General Blaze

debility.
(Include common within month of death)

Date of operation..... Underline the

Major findings of operations:	cause to which
-------------------------------	----------------

death should be

of autopsy:	charged statu- tionally.
-------------	-----------------------------

2. If death was due to external causes, fill in the following:

g) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____

Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of income *Wm. V. S. - 100%*

23. Signature *[Signature]* M.D. *[Signature]*

Address 2802 Zacherly Date signed 9-2-42

VN 184

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07829

Pibber
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07829

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County Baltimore(c) City or town Towson

(If outside city or town limits, write RURAL and give town)

(d) Street No. 200 Washington Ave.

(If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME

Margaret Augusta Pibber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Pibber

6 (c) If alive, give age

years7. Birth date of deceased (mo., day, yr.) Nov. 2, 1864

8. AGE:

Years

Months

Days

If less than one day

79930hr.min.

9. Birthplace

Baltimore Co.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

John Amrein

13. Birthplace

Germany

14. Maiden Name

Mary Shaffer

15. Birthplace

Germany16 (a) Informant Helen L. Zinkhan(b) Address 202 Washington Ave17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 9, 1943

(month) (day) (year)

(c) Cemetery or crematory

Prospect Hill Cem.

Location

Towson, Maryland

18 (a) Funeral director

John Brown Song

(b) Address

Towson, Md.

SEP 9 1943

(b)

H. Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1943, at M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1943, to Sept. 1 1943, and that I last saw her alive on Sept. 1 1943.

Immediate cause of death

LOBAR PNEUMONIA

Duration

Due to PULMONARY EDEMADue to ARTEROSCLEROTIC HEART DISEASEOther Conditions Generalized edema, senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature James N. McCook Jr.Address Union Memorial HospitalDate signed 9-1-43

R. D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07830

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2017 Eastern ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2

(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 Eastern ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph Dubiel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Eva.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Not known

8. AGE: Years

Months

Days

If less than one day

About 62

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Jos.

13. Birthplace

Poland

14. Maiden Name

Maryanna

15. Birthplace

Poland

16 (a) Informant

Eva Dubiel

(b) Address

2017 Eastern ave

17 (a)

Burial

(b) Date thereof 9-6-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

18 (a) Funeral director

W. L. Zialkowski

(b) Address

2007 Eastern ave

19 (a)

SEP 3 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943 to Sept 2 1943, and that I last saw h — alive on Sept 1, 1943.

Immediate cause of death

Coronary Sclerosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Arthur J. J. J.

Address 2007 Eastern ave. Date signed 9/3/43

Where necessary, with expanding ink. Every item of information should be carefully and correctly written. Physicians: please write the causes of death clearly and legibly.

G 07831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07831

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 830 South Bond Street
- (c) Hospital or institution: Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
- (e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 830 S. Bond Street
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jadwiga Moskwik

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-05-4680

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband Frank Moskwik6 (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) 1887 ?8. AGE: Years 56 ? Months Days If less than one day
hr. min. 9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation Packing House Work

11. Industry or business

12. Name SUCHY13. Birthplace Poland14. Maiden Name unknown15. Birthplace unknown16 (a) Informant Frank Moskwik(b) Address 830 So. Bond street17 (a) Burial (b) Date thereof 9-6-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.18 (a) Funeral director George A. Weber(b) Address 705 So. Ann streetSEP 3 - 1943 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3rd 1943 at 5:30 AM21. I certify that death occurred on the date above stated, that I attended deceased from Aug 25 1943 to Sept. 3 1943 and that I last saw her alive on Sept. 3 1943

Immediate cause of death

ARTERIOSCLEROTIC CARDIO-
VASCULAR DISEASE

Duration

1943 ??

Due to

Due to

Other Conditions EPILEPSY??

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
- (e) Means of injury

23. Signature Joseph F. KoenigAddress 207 S. Charter St. Date signed 9/5/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07832

BALTIMORE CITY HEALTH DEPARTMENT

G 07832

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
114 N. Decker St.

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore,

(If outside city or town limits, write RURAL and give town)

(d) Street No. 114 N. Decker St.

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles V. Keyser

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-07-4465

4. Sex
Male5. Color or race
white6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife

Estelle Ruth Scates

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

2/17/82

8. AGE: Years

Months

Days

If less than one day

61

6

15

hr.

min.

9. Birthplace

Fred. Md.

(Town, county, and state)

10. Usual Occupation

Steam Fitter

11. Industry or business

12. Name John C. Keyser

13. Birthplace Fred. Co. Md.

14. Maiden Name Sarah Hahn

15. Birthplace Fred. Co. Md.

16 (a) Informant Mrs. Estelle S. Keyser

(b) Address 114 N. Decker St.

17 (a) Burial

(b) Date thereof Sept. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet Cemy.

Location

Frederick, Md.

18 (a) Funeral director

John O. Mitchell-Lindner

(b) Address

1900 Eutaw Place

19 (a)

SEP 3 - 1943

(Date received by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1943

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943, Day 2, 1943, and that I last saw him alive on Sep 2, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature of J. K. G. M. D.

2936 E. Baltimore St. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07833

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Madison & Howard*
- (c) Hospital or institution: *Maryland General Hospital*
- (d) Length of stay in hospital or inst. (yrs., mos., or days) *6*
- (e) Length of stay in Baltimore (yrs., mos., or days) *50 yrs.*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
- (c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *701 Cathedral St.*
(If rural give location)
- (e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME

Rev. Robert William H. Weech

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

*CLARA E. ~~Weech~~ Weech*6 (c) If alive, give age *73* years

7. Birth date of deceased (mo., day, yr.)

Aug. 1, 1866

8. AGE: Years

77

Months

1

Days

1

If less than one day

9. Birthplace

Quilleyville, Md.

(Town, county, and state)

10. Usual Occupation

Minister

11. Industry or business

FATHER
MOTHER12. Name *William S. Weech*13. Birthplace *Nassau - ~~Fla.~~ D. W. I.*14. Maiden Name *MARY ~~Ann~~ A. Sewell*15. Birthplace *Maryland*16 (a) Informant *Mr. Charles S. Weech*(b) Address *701 Cathedral St.*17 (a) *Cremation* (b) Date thereof *9/4/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *London Park Cem.*
Location *Fred. Ave. Balto. Md.*18 (a) Funeral director *John O. Mitchell, Sons*(b) Address *1900 East Ave. Baltimore, Md.*19 (a) *SEP 3 - 1943* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 2* 1943, at *1:45 P*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug. 28* 1943, to *Sept 9* 1943, and that I last saw him alive on *Sept 2* 1943.

Immediate cause of death *Metastatic**carcinoma - primary site in stomach*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature *L. Herman Williams* M. D.Address *Md. Gen. Hosp.* Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

(over) Sept 3, 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07834

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07834

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland Charles & 34th. Sts.
Greenway Apts.

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore,

(If outside city or town limits, write RURAL and give town)

(d) Street No. Greenway Apts.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Elizabeth M. MacDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Female5. Color or race
white

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife J. Stuart MacDonald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1856

8. AGE: Years 87 Months 4 Days 15 If less than one day hr. min.

9. Birthplace Boston, Mass.

(City, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Wm. D. Macy

13. Birthplace R. I.

14. Maiden Name Marilla Caverno

15. Birthplace New Hampshire

16 (a) Informant Marjorie C. Marr

(b) Address 605 St. Paul St.

17 (a) Burial (b) Date thereof 9/4/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemy.

Location Balto. Md.

18 (a) General director John O. Mitchell

(b) Address 1000 E. Pratt St. Baltimore, Md.

19 (a) (b) Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1943, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1, 1943, to Sept. 2, 1943, and that I last saw him alive on Sept. 1, 1943.

Immediate cause of death

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. F. Kautz

Address 1 E. Randell St. Date signed 9/3/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G 02835
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Wilkins & Caton Ave.*
(c) Hospital or institution: *St. Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *13*
(e) Length of stay in Baltimore (yrs., mos., or days) *21*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3812 Hickory Ave.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mrs. Mary Justice
3 (b) If veteran, name war
3 (c) Social Security Account
No. *215-09-9371*

4. Sex *female* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced. *widowed*
6 (b) Name of husband or wife *Wm. M. Justice*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 2, 1882*

8. AGE: Years *61* Months *3* Days *29* If less than one day hr. min.

9. Birthplace *Maryland*
(Town, county, and state)

10. Usual Occupation *Seamstress*

11. Industry or business *Heller Mattress Co*

FATHER 12. Name *Henry*
13. Birthplace *Md.*

MOTHER 14. Maiden Name *Mary*
15. Birthplace *Md.*

16 (a) Informant *Wm. Justice*
(b) Address *3812 Hickory Ave.*

17 (a) *Burial* (b) Date thereof *Sept 4/43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Holy Redeemer*
Location *Belair Road.*

18 (a) Funeral director *Chenoweth & Sonoran*
(b) Address *3615-17 Chestnut Ave.*

19 (a) *SEP 3 - 1943* (b) *Huntington Williams, Md.*
rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/1* *1943* at *2 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *8/20* *1943* to *9/1* *1943*, and that I last saw her alive on *9/1* *1943*.

Immediate cause of death *Arteriosclerotic C-V-D* Duration

Due to

Due to

Other Conditions *Diabetes mellitus*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Arthur Probert*

Address *St. Agnes Hosp.* Date signed *9/1/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

07836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07836

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2303 Harlem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2303 Harlem Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

August Buttner,

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-10-5037

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Caroline Buttner,

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) September 16, 1876

8. AGE: Years

66

Months

11

Days

13

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Bookkeeper

11. Industry or business

Meat

FATHER
MOTHER

12. Name Michael Buttner,

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany

16 (a) Informant Mrs. Caroline Buttner,

(b) Address 2303 Harlem Ave

17 (a) Burial (b) Date thereof Sept. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

Baltimore City

18 (a) Funeral director

George W. Little.

(b) Address

2700 Edmondson Ave.

19

SEP 9 - 1943

(b)

Registrar

H. H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEP 3 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 3 1943 to Sep 3 1943

and that I last saw her alive on Aug 27 1943

Immediate cause of death

Cranial Thrombosis

Due to

Hypertensive Cardiovascular Disease

Due to

Essential Hypertension

Other Conditions

Chronic Pulmonary Infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Albert J. H. H.

Address

2302 Edmondson Ave

Date signed 9/3/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07837

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **1746 E. 25th St.**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **38 Yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County **Baltimore**
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **1746 E. 25th St.**
 (If rural give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country

3 (a) FULL NAME

Carmelo Lucchesi

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. **None**

4. Sex

Male

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widowed6 (b) Name of ~~XXXXXX~~ wife **late Pietrina**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 14 1880**

8. AGE:	Years	Months	Days	If less than one day
62	8	9	17	hr. min.

9. Birthplace **Calascibetta Italy**
(Town, county, and state)10. Usual Occupation **Retired**

11. Industry or business

12. Name **Caetano Lucchesi**13. Birthplace **Italy**14. Maiden Name **Josephine Villano**15. Birthplace **Italy**16 (a) Informant **Thomas Lucchesi (Son)**(b) Address **2813 Harve Ave**17 (a) **Burial** (b) Date thereof **Sept. 4/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Holy Redeemer Cem.**
Location **Belair Rd. Baltimore Md.**18 (a) Funeral director **Frank Della Hone**(b) Address **52 N. Morley St.**19 (a) **SEP 9 1943** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 1 1943** at **1:15 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **June 1942** to **Sept. 1 1943** and that I last saw him alive on **Aug 31 1943**.

Immediate cause of death

Chronic myocarditis
Cardiac hypertrophy
 Due to **Hypertension**
 Due to **Cardiac degeneration**
 Other Conditions **atherosclerosis**

Duration

(Include pregnancy within 3 months of death)

Date of operation **✓**Major findings of operation: **✓**

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **✓**
 (b) Date of occurrence **✓** at **✓** M
 (c) Where did injury occur? **✓**
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**
 (Specify type of place)
 (e) Means of injury **✓**

23. Signature **P. J. Hurley**
Address **1108 Northton** Date signed **8/2/43**

07838

AB-

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07838
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **4940 Eastern Ave.**
 (c) Hospital or institution:
Baltimore City Hospitals
19 Yrs - 1 mo. 1 day
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **38 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
No Home
 (d) Street No. (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Frank Gillen

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced.**Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12/14/1881

8. AGE:

Years

Months

Days

If less than one day

61**8****11**

hr.

min.

9. Birthplace **Penna.**

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name **John G. Gillen**13. Birthplace **Germany**

MOTHER

14. Maiden Name **Kate Miller**15. Birthplace **Germany**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records.**

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location **UNIVERSITY MEDICAL SCHOOL SEP 2 1943**

18 (a) Funeral director

Commissioner of Health

(b) Address

19

SEP 2 - 1943**Huntington Williams, M.D.**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/25 1943 at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from **7/1 1943** to **8/25 1943** and that I last saw him alive on **8/25 1943**.

Immediate cause of death

Cardiac failure

Due to

arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Seigman

Address

10 C.H.

Date signed

9/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

07839

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 842 E. Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 842 E. Pratt Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Legiad

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4

8. AGE: Years Months Days If less than one day
52 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 2 1943

18 (a) Funeral director Commissioner of Health

19 (a) SEP 3-1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-1943, at 7:00 AM

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Howard J. Mulder M.D.
Medical Examiner.

Date signed 8/20/43

7840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07840

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *0-0-A*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *260 Spring St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Virginia Bedford

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

70

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 3-1943

(Date rec'd by registrar)

Commissioner of Health

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-19-1943* at *2 P.* M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *her* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *8-19-43* at *M.*

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Howard J. Waldeis* M.D.Date signed *8-19-43* Medical Examiner.

07841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1529 W. Baltimore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1529 W. Baltimore St.
(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Carol Elizabeth Thomas

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 25, 19438. AGE: Years Months Days If less than one day
0 0 1 21 hr. 50 min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Carroll Thomas13. Birthplace Baltimore, Md.14. Maiden Name Sallie Nelson15. Birthplace Borfolk, Virginia16 (a) Informant Carroll Thomas(b) Address 1529 W. Baltimore St.17 (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 2 194318 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 2 1943 (b) Huntington Williams, M.D.
(State & City Registrar) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1943, at 9 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943 to Aug 26 1943 and that I last saw him alive on Aug 25 1943

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature J. J. MorganAddress University of Date signed

M. D.

G 07842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHV G 07842
937 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.C.A. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 207 N. Fremont Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Herbert Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 3, 1890

8. AGE:

Years

Months

Days

If less than one day

53

1

28

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Elevator Operator

11. Industry or business

FATHER
MOTHER

12. Name

Billy Campbell

13. Birthplace

Baltimore, Md.

14. Maiden Name

Unknown

15. Birthplace

?

16 (a) Informant

Bertrude Matthews

(b) Address

207 N. Fremont Ave.

17 (a)

Burial

(b) Date thereof

Sept 4, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

222 N. Schroeder St.

EP 3-1943

(Date received by registrar)

H. J. Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/1

1943, at 4:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. Michael, M.D.

Date signed

9/1/43

Medical Examiner.

G 07844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address Baltimore, Maryland

(c) Hospital or institution:

Johns Hopkins Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1219 Madison Avenue

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

GEORGE ROBUSTER BARNES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1911

8. AGE:

Years

Months

Days

If less than one day

3132820

hr.

min.

9. Birthplace Wilson, N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Will Barnes13. Birthplace Wilson, N.C.

MOTHER

14. Maiden Name Hattie Barnes15. Birthplace Wilson, N.C.16 (a) Informant Hattie Smith(b) Address 165 2nd St. Englewood, D.C.17 (a) Burial

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 3 - 1943

MEDICAL CERTIFICATION

1:50 A.

20. DATE OF DEATH August 31, 1943 at M21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of the abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 8-31-43 at 11:25 P. M.(b) Where did injury occur? 714 N. Spring Street(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No(d) Means of injury Shot in abdomen.23. Signature H. Z. Wallenmeyer M.D.Date signed 8-31-43

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07845

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1216 N. 40th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

Robert F. Leppo

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-07-3813

4 Sex

Male

5 Color of race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Martha M. Leppo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1874

8. AGE: Years Months Days If less than one day

69 6 8 hr min.

9. Birthplace Baltimore Co. Md.

10. Usual Occupation Barber (Foreman)

11. Industry or business Emerson Hotel

12. Name Louis G. Leppo

13. Birthplace Maryland

14. Maiden Name Ann Caroline Campbell

15. Birthplace Maryland

16 (a) Informant Mrs. Martha M. Leppo

(b) Address 1216 N. 40th St.

17 (a) Burial (b) Date thereof Sep. 5, 1943

(c) Cemetery or crematory Wesley Chapel

Location Carroll Co. Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3634 E. Egan Rd.

SEP 3-1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1216 N. 40th St. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1943, at 5 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942, to Sept. 2, 1943, and that I last saw him alive on Sept. 2, 1943.

Immediate cause of death

Carcinoma of Prostate

Due to

Due to

Other Conditions Metastases

(Include pregnancy within 3 months of death)

Date of operation June 1942

Major findings of operation: Carcinoma

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

of prostate.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward Egan

Address 18 E. Egan Rd.

Date signed 9/3/43

G 07846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07846

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Don

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 570 Wilson St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME DAVID H. CHAPMAN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

Col6 (a) Single, married, widowed, or
divorced.Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 19258. AGE: Years 18 Months 2 Days 29
If less than one day hr. min.9. Birthplace Charlotte Court Va.
(Town, county, and state)10. Usual Occupation Labourer

11. Industry or business

12. Name John Chapman13. Birthplace Charlotte Court Va.14. Maiden Name Bessie Holcombe15. Birthplace Charlotte Court Va.16 (a) Informant Bessie Chapman(b) Address 1721 W. Lamar St.17 (a) Burial (b) Date thereof Sept 3, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Keysville Va.

Location

18 (a) Funeral director Mr. Kate R. Williams(b) Address 322 W. Carroll St.19 (a) SEP 3 1943 (b) Washington Williams

VA 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1943 at 6:50 PM21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hemorrhage, subarachnoid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9-1-43 at 8:15 P. M.(b) Where did injury occur? Washington near(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work?(d) Means of injury Pedestrian struck by23. Signature W. J. Allenweber M.D.Date signed 9-2-43

07847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07847

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2202 Wilkens Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2202 Wilkens Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Walter C. Cogswell

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Mary B. Cogswell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1866

8. AGE: Years Months Days If less than one day

77

7

7

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Painter Carpenter

11. Industry or business

12. Name Charles Cogswell

13. Birthplace Baltimore, Md.

14. Maiden Name Unknown

15. Birthplace United States

16 (a) Informant Mr. Richard Cogswell

(b) Address 2202 Wilkens Ave.

17 (a) Burial (b) Date thereof Sept. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Miller Amorran

(b) Address 1005 W. Baltimore St.

EP 3 1943 Date of registration Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1943, at 6.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2, 1943, to Sept 2, 1943, and that I last saw him alive on Sept 2, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

Due to Atherosclerotic Cardiovascular

Disease

Due to Hypertension

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Herman H. Bayless

Address 1600 Wilkens Ave. Date signed 9/3/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07848

Gedra
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 162 B

G 07848

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Saratoga Street 18*(c) Hospital or institution: *Mercy Hospital*(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 mos.*(e) Length of stay in Baltimore (yrs., mos., or days) *45 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *816 1/2 Lombard St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Casimir Gedra

3 (b) If veteran, name war

☒

3 (c) Social Security Account

No. ☒

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Barbara*6 (c) If alive, give age *65* years

7. Birth date of deceased (mo., day, yr.)

1891

8. AGE: Years

72

Months

Days

If less than one day

hr.

min.

9. Birthplace

Lithuania
(Town, county, and state)10. Usual Occupation *Tailor*11. Industry or business *Garment*

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address *816 1/2 Lombard St*17 (a) *Burial*
(Burial, cremation, or removal)(b) Date thereof *Sept 6 43*
(month) (day) (year)

(c) Cemetery or crematory

Location *Holy Redeemer Church*

18 (a) Funeral director

(b) Address *622 1/2 Washington Blvd*

SEP 4 - 1943

VB 154

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 2 1943* at *9:20 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *July 7 1943* to *Sept 2 1943*, and that I last saw him alive on *Sept 2 1943*.Immediate cause of death *Coronary Failure*

Duration

Due to *Semity*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Henry F. Zangara*Address *Mercy Hospital* Date signed *9/2/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TL - 81976

07849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07849
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **2 mos., 19**
(e) Length of stay in Baltimore (yrs., mos., or days) **60 yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **517 W. Biddle St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mary Elizabeth Riley

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.
Widowed

6 (b) Name of husband or wife **Albert Riley (D)**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Aug. 8, 1858**

8. AGE: Years Months Days If less than one day

85

0

23

24

hr.

min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name **Benjamin Barnes**

13. Birthplace **Md.**

14. Maiden Name **Serine Amos**

15. Birthplace **Md.**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **9-4-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Central**
Location **Baltimore City**

18 (a) Funeral director **James H. Hendley**

(b) Address **578 W. Biddle St.**

19 **SEP 4 - 1943**

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/2 1943 at 2:40 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **7/1 1943 to 9/2 1943** and that I last saw her alive on **9/2 1943**.

Immediate cause of death **Multiple pulmonary emboli; broncho-pneumonia; cardiac failure**
Due to **A.S. C.V. disease; thrombi of iliac & femoral veins**

Other Conditions **Hem. arterio-sclerosis; senility**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **See above**

22. If death was due to external causes, fill in the following

- (a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) **While at work?**
(e) Means of injury

23. Signature **E. L. Sengman**
Address **D. C. H.** Date signed **9/2**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

07850

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 SEP 4 - 1943 (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from and that I last saw her alive on

Immediate cause of death
Coronary Occlusion

Due to Endocarditis

Due to

Other Conditions Myocarditis

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration
few hrs.

unknown

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

Approved by Howard J. Madsen, M.D.

G 07851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07851

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Murray Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1217 N. Lombard St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry Thurman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Widowed6 (b) Name of husband or wife Hannie Schollie Thurman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-18868. AGE: Years Months Days If less than one day
62 10 18 hr. min.9. Birthplace Balto Md.
(Town, county, and state)10. Usual Occupation Paper Hauler11. Industry or business Balto News Post12. Name Unknown13. Birthplace Balto Md14. Maiden Name Unknown15. Birthplace Balto Md.16 (a) Informant Mr Frank Thurman(b) Address 1824 N. Dearham St17 (a) Burial (b) Date thereof 9-7-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Cemetery
Location E North Avenue18 (a) Funeral director Alfred L. Hiltz Jr(b) Address 1606 N. Chester Street19 (a) SEP 4 - 1943 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1943 at 8 A M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtainedby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Myocardial Infarction - Coronary Arteriosclerosis

Due to

Other Conditions Senile Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature Harold J. Albrecht M.D.Date signed 9-3-43 Medical Examiner.

G 07852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07852
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

ROA. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 917 Bruce St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John Anthony

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-12-7133

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

59

min.

9. Birthplace

Smith Center

(Town, county, and state)

10. Usual Occupation

Coal yard

11. Industry or business

Steep coal co

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Father, Smith, Fred

(b) Address

840 Long St.

17 (a)

Burial

(b) Date thereof

Sept 4, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Mount Zion

Location

Baltimore County

18 (a) Funeral director

Joseph A. Smyly

(b) Address

499 Mount Street

19 (a)

SEP 4 - 1943

H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/1

1943, at 1:20 A.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic
Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. McHally, M.D.

Date signed

9/1/43

Medical Examiner.

Caution: When filling out this form, every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07853
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *N. Calver St.*
(c) Hospital or institution: *St. Mary's Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *27*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *6100 Marquette Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Silbert Messick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Single*

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb 12 1943*

8. AGE: Years Months Days If less than one day
6 22 21 hr. min.

9. Birthplace *Baltimore*
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name *Silbert B. Messick*
13. Birthplace *Maryland*
MOTHER 14. Maiden Name *Verna B. Rainey*
15. Birthplace *Tenn*

16 (a) Informant *Silbert B. Messick*
(b) Address *6100 Marquette Ave.*

17 (a) *Burial* (b) Date of death *Sept 3 1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematorium *Parkwood*
Location *Agyle Ave*

18 (a) Funeral director *W. G. Hudson*
(b) Address *360 E. Baltimore St.*

19 *SEP 4 - 1943* (b) Registrar *William H. Williams, M.D.*
VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 3 1943* at *2:15* M

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 2 1943* to *Sept 3 1943* and that I last saw him alive on *Sept 3 1943*.

Immediate cause of death *Post-operative Collapse*
Delayed Shock
Due to *Intussusception*

Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation *Sept 2*
Major findings of operation: *Intussusception of 10-12 inches of small intestine of autopsy.*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *R. J. Jasser* M. D.
Address *Maryland* Date signed *9-3-43*

Duration
2 hrs
24 hrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

G 07854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07854

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 8 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Landowne
(If outside city or town limits, write BUR and give town)

(d) Street No. 224 Elizabeth Ave

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Charles R Barbee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

June 23/1943
8. AGE: Years Months Days If less than one day
2 11 9 hr. min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Charles A Barbee

13. Birthplace Va

MOTHER

14. Maiden Name Beanie E Helwig

15. Birthplace Landowne Md

16 (a) Informant Mr Charles A Barbee

(b) Address 224 Elizabeth Ave

17 (a) Burial (b) Date thereof 9/4/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Ave

18 (a) Funeral director William M. March

(b) Address 715 Lis St

19 (a) SEP 4-1943

(Date rec'd by registrar)

VS 3

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1943, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 (6 PM) 43 to 9-2 (11:45) 43 and that I last saw him alive on 9-2-43

Immediate cause of death
Toxic Shock + generalized
Peritonitis.Due to Perforation of ileum
Non-Specific Enteritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-2-43

Major findings of operation:

See above

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward J. Kreymer

Address Bon Secours Hospital 9-2-43

G 07855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07855

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *916 S. Charles St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *23*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William Franklin Hardesty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 28, 1943*

8. AGE: Years Months Days If less than one day

5 *6* *5* hr. min.9. Birthplace *Baltimore*
(Town, county, and state)10. Usual Occupation *None*

11. Industry or business

12. Name *Alex Hardesty*13. Birthplace *Fairmount, W. Va.*14. Maiden Name *Opaline Fortune*15. Birthplace *Virginia*16 (a) Informant *Mr Alex Hardesty*(b) Address *916 S. Charles St.*17 (a) *Burial* (b) Date thereof *9/4/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Green Haven*
Location *Annapolis Blvd*18 (a) Funeral director *William Mareck*(b) Address *715 Light St.*19 (a) *Dr. William H. B.* (b) *Dr. William H. B.*

SEP 4 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *916 S. Charles*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 3, 1943* at *4:10* AM21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 26, 1943* to *Sept 3, 1943* and that I last saw him alive on *Sept 3, 1943*

Immediate cause of death

*Convulsions*Due to *His Precious*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)(e) Means of injury *W.P. Campbell*23. Signature *W.P. Campbell*Address *1644 N. Annapolis* Date signed *Sept 3, 1943*

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 07856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07856

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HENRY WARD

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-07-5243

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr) August 1899

8. AGE: Years

44 43 ?

Months

Days

If less than one day

hr.

min.

9. Birthplace

Cambridge, Md.

(Town, county, and state)

10. Usual Occupation

Fisherman

11. Industry or business

FATHER

12. Name

Howard Cornish

13. Birthplace

Cambridge, Md.

MOTHER

14. Maiden Name

Mary Ward

15. Birthplace

Cambridge, Md.

16 (a) Informant

Clarence E. Cornish (Son)

(b) Address

1210 Union St

17 (a)

Burial

(b) Date thereof

9-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore National

Location

Baltimore Md.

18 (a) Funeral director

Charles S. Cooper

(b) Address

514 N. Calhoun St

19 (a)

SEP 4-1943

H. Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

654 Berry Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1943, at 8 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Hypertrophy & dilatation of

Due to

heart

Other Conditions

Syphilitic aortitis

Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Howard J. Mulheisen

M.D.

Date signed

9/20/43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07857

G 07857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

122 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Broadway
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FREEMAN CULBRETH

3 (b) If veteran, name war World's War
3 (c) Social Security Account No. 115-07-3390

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lena Cooper
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1897

8. AGE: Years 46 Months 0 Days 21 20 hr. min.

9. Birthplace Marine, Ill.
(Town, county, and state)

10. Usual Occupation Chef 8/27/43

11. Industry or business -

12. Name Jim Culbreth

13. Birthplace Marine, Ill.

14. Maiden Name Core I

15. Birthplace Marine, Ill.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Sept. 7/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U. S. National
Location Frederick Rd.

18 (a) Funeral director Lilly & Seiler Inc.

(b) Address 403 S. Wolfe St.

19 SEP 4 - 1943 (b)

V8 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH September 3, 1943, 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29, 1943, to Sept. 3, 1943, and that I last saw him alive on Sept. 3, 1943.

Immediate cause of death Peritonitis, acute, generalized 2 da.

Due to Ileus paralytic 2 da.

Due to Ileitis, regional, 1st stage, Unk. terminal ileum

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9/1/43

Major findings of operation: Cecostomy; Ileostomy

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. S. Dorman

Address Baltimore, Md. Date signed 9/4/43

Va-13624

PHYSICIAN

Underline the cause to which death should be charged statistically.

07858

HEALTH DEPARTMENT—CITY OF BALTIMORE

07858

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 DENISON ST. St. Ward)

Length of residence in city or town where death occurred 85 yrs. mos. 2 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME ELIZABETH BRUNE

(a) Residence: No. 3031 O'DONNELL ST.

(Usual place of abode)

St. 1-1 Ward.

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

If U.S. Veteran specify WAR NO

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. Color or Race WHITE 5. Single, Married, Widowed, or Divorced (write the word) WIDOW

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of PETER BRUNE

6. DATE OF BIRTH (month, day, year) AUG. 13 1858

7. AGE Years 85 Months 0 Days 20 19 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HOUSE WIFE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. AT HOME

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) BALTIMORE MD. (State or country)

13. NAME MALCOLM BEATON

14. BIRTHPLACE (city or town) BRITISH COLUMBIA (State or country)

15. MAIDEN NAME MARY MARO

16. BIRTHPLACE (city or town) IRELAND (State or country)

17. INFORMANT FRANK BRUNE (SON)

(Address) 3031 O'DONNELL ST.

18. BURIAL, CREMATION, OR REMOVAL

Place OAK LAWN Date SEPT. 7 1943

19. UNDERTAKER Jolly and Geiler / N.C. (Address) 403 S. WOLFE ST.

FILED EP 4-1943

Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/2 1943

22. I HEREBY CERTIFY: That I attended deceased from 9/1 1943 to 9/2 1943

I last saw her alive on 9/2 1943 Death is said to have occurred on the date stated above, at 4:40 p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
Hypertensive & Arteriosclerotic
Cardiovascular Disease

Date of onset 8/19/43

10 yrs

Other contributory causes of importance:

Generalized Arteriosclerosis
Senility

10 yrs

5 yrs

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? I.S.G. Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so specify

(Signed) Thos. E. Punch M. D.

(Address) 3624 Edmondson Avenue

Baltimore, Md.

G 07859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07859
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Wilkins Ave and Baton Ave*
 (c) Hospital or institution: *St. Agnes Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *26*
 (e) Length of stay in Baltimore (yrs., mos., or days) *13 days*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *417 N. Highland Ave*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

John Vogel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-23-1878

8. AGE:

Years

Months

Days

If less than one day

*65**8**9*

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Copper worker

FATHER

12. Name

John (dec'd)

13. Birthplace

Germany

MOTHER

14. Maiden Name

Amelia (dec'd)

15. Birthplace

Germany

16 (a) Informant

Albert Vogel (Son)

(b) Address

3217 Dudley Ave

17 (a)

Burial

(b) Date thereof

(Burial, cremation, or removal)

Sept. 4-43

(c) Cemetery or crematory

Schwartz

Location

Adams St

18 (a) Funeral director

Lilly and Quilley, INC

(b) Address

403 S. Wolfe St.

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 1, 1943* at *1:30 p.m.*21. I certify that death occurred on the date above stated; that I attended deceased from *7/19* *1943* to *9/1* *1943*, and that I last saw him alive on *9/1* *1943*.

Immediate cause of death

Myocardial infarct

Due to

Ventriculitis of

Due to

Esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. F. Bynum

Address

*St. Agnes Hosp*Date signed *9/1/43*

M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 4 1943 *Washington Williams, M.D.*

G 07861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 83a

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 15 E 21st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age 10 years

7. Birth date of deceased (mo., day, yr.) June 17 1885

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date thereof

(b) Date thereof

(c) Cemetery or cremation

Location

18 (a) Funeral director

(b) Address

19 (a) Date signed

1943

VS 180

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 15 E 21st St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 3 1943 at 7:45 P

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943 to 9/3 1943 and that I last saw him alive on 9/3 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Address 2020 N. Charles

Date signed

9/4/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓
Permanent Registered No. 07862525 N. Le Claire Ave, Chicago
Ill.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Murray Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 211 N. Bay St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Sidney C. Talbot

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 21, 1893

8. AGE:

Years

Months

Days

If less than one day

50

1

11

hr.

min.

9. Birthplace

Topeka Kan.

(Town, county, and state)

10. Usual Occupation

Engineer

11. Industry or business

Race Lines

FATHER

12. Name

Richard Talbot

13. Birthplace

Unknown

MOTHER

14. Maiden Name

Laura de Costa

15. Birthplace

Unknown

16 (a) Informant

Pearl Talbot

(b) Address

525 N. Le Claire Ave

17 (a)

Burial

(b) Date thereof

9/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Chicago, Ill.

Location

18 (a) Funeral director

Wm. J. Pickner & Sons

(b) Address

North & Thoma Ave.

Washington, D.C.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-2-

1943, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Marsilio M.D.

Date signed 9-3-43

Medical Examiner.

SEP 4 - 1943

VR 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07863

159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4102 Prior Ave.

(If rural give location)

Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

FRANK LETTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-43

8. AGE:

Years

Months

Days

If less than one day

1 hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Harold Warren Letts

13. Birthplace Charleston, South Carolina

14. Maiden Name Laura May Abbey

15. Birthplace England

16 (a) Informant Harold Warren Letts

(b) Address 4102 Prior Ave.

17 (a) Burial (b) Date thereof 9-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Leonard J. Ruck

(b) Address 5805 Maryland Rd.

SEP 4 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1943 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1943 to 8-30 1943; and that I last saw him alive on 8-30 1943.

Immediate cause of death

prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. B. Ballina, M.D.

Address

St. Joseph's Hosp.

Date signed 8/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07864
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1400 - N. Caroline

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mo., or days)

1 day

(e) Length of stay in Baltimore (yrs., mo., or days)

27

3 (a) FULL NAME

JAMES LETTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-30-43

8. AGE: Years Months Days

If less than one day

1 hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Harold Warren Letts

13. Birthplace Charleston, South Carolina

14. Maiden Name Laura May Abbey

15. Birthplace England

16 (a) Informant Harold Warren Letts

(b) Address 4102 Prior Ave.

17 (a) Burial (b) Date thereof 9-4-33

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Leonard J. Rusch

(b) Address 5305 Harbor Rd

SEP 4 1943

VB 154

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4102 Prior Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-43 19, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1943 to 8-30 1943, and that I last saw him alive on 8-30 1943.

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address St. Joseph's Hosp. Date signed 8/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07865

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07865
Registered No.

440142

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Dr. William M. Chew

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Catherine S.6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

3-1-04

8. AGE:

Years

39

Months

6

Days

3

If less than one day

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Physician

11. Industry or business

FATHER
MOTHER

12. Name

Frank L. Chew

13. Birthplace

Va.

14. Maiden Name

Mary Vest

15. Birthplace

Va.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) Burial

(b) Date thereof

Sept 6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arlington

Location

Arlington Va

18 (a) Funeral director

J. L. Hopping

(b) Address

Annapolis, Md.

SEP 4 - 1943

Huntington Williams, M.D.

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Anne Arundell

(c) City or town

Annapolis

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Apartment 7

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 4, 1943 at 8:20 A. M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25, 1943 to Sept. 4, 1943 and that I last saw him alive on Sept. 4, 1943

Immediate cause of death

Respiratory failure

Duration

Due to

Involvement of both recurrent laryngeals (?)

Due to

Malignant mediastinal tumor

Other Conditions

None

(Include pregnancy within 3 months of death)

Date of operation

8/20/43

Major findings of operation:

Inoperable mediastinal tumor

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. C. Sanford

Address

JOHNS HOPKINS HOSPITAL

Date signed

9/4/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07866
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James T. Dawson

3 (b) If veteran name war

3 (c) Social Security Account
No.

4. Sex

7

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

James T. Dawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1869

8. AGE: Years Months Days If less than one day
74 6 9 hr. min.9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Millard Fackenthal

13. Birthplace Pennsylvania

14. Maiden Name Annagisa Fetterhoff

15. Birthplace Pa

16 (a) Informant Mrs. Paul Meriton (daughter)

(b) Address 3408 Guilford Terrace

17 (a) Burial, cremation, or removal (b) Date thereof 9/6/43

(c) Cemetery or crematory Williamsport Pa

Location Williamsport Pa

18 (a) Funeral director J. J. Foley

(b) Address 1318 Light St.

19 (a) Date rec'd by registrar

SEP 4 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town City
(If outside city or town limits, write RURAL and give town)(d) Street No. 3408 Guilford Terrace, City
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/43 1943 at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/43 19 to 9-3-43 and that I last saw her alive on 9/3/43 19

Immediate cause of death Cerebral Hemorrhage Duration

Due to Arterio-Sclerotic Heart Disease

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Herbitt, Jr.

Address Union Memorial Hospital Date signed 9-3-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07867

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07867
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 3rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Harford
(c) City or town: Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William James Connellee, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 1, 1924

8. AGE:

Years

Months

Days

If less than one day

19

9

9

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
BROTHER

12. Name Wm James Connellee, Sr.

13. Birthplace Virginia

14. Maiden Name Elsie Green

15. Birthplace Maryland

16 (a) Informant Ms. Wm. J. Connellee

(b) Address 476 N. Calvert St. Aberdeen Md

17 (a) Burial

(b) Date thereof Sept. 6, 1945

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Bakers

Location

Chesapeake Md

18 (a) Funeral director Henry J. Janning & Sons

(b) Address

Chesapeake Md

SEP 5 - 1945

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1945 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1945 to Sept. 4, 1945, and that I last saw him alive on Sept. 4, 1945.

Immediate cause of death

Cardiorespiratory Arrest

Due to Virus encephalitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Mungatone Jr.

Union Memorial Hosp.

Address 3rd & Calvert

Date signed 9/4/45

Duration

Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

07868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07868

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Mercy Hospital*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) *3*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County
(c) City or town *Baltimore City*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *922 Fawn St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Adelina Lavezza

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F*

5. Color or race *W*

6 (a) Single, married, widowed, or divorced. *Widow*

6 (b) Name of husband or wife *Joseph Lavezza*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb 2 - 1873*

8. AGE: Years *70* Months *7* Days *1*
If less than one day hr. min.

9. Birthplace *Balto Ind*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Angelo Bacigalupo*
13. Birthplace *Italy*

14. Maiden Name
15. Birthplace *Italy*

16 (a) Informant *Don Frank Lavezza*
(b) Address *2426 E. Lanvale St*

17 (a) *Buried* (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *New Cathedral*
Location *Belair Road*

18 (a) Funeral director *Frank V. Pipitone*
(b) Address *281 P. E. Balto*

19 (a) *SEP 5 - 1943* (b) *H. H. Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 3 1943 5:45 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-29 1943* to *9-3 1943* and that I last saw her alive on *9-3 1943*.

Immediate cause of death

Cardiac Failure
Arteriosclerosis C.V. Disease
Dementia Toxicum from Acute Nephritis

Duration *24 hours*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *R. J. Janssen*
Address *Mercy Hospital* Date signed *9-3-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07869

JL - 74960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07869
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4940 Eastern Ave.
- (c) Hospital or institution: Baltimore City Hospitals
- (d) Length of stay in hospital or inst. 1 - 2 - 2 (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1414 Eutan Place
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jacob Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced. Widowed6 (b) Name of husband or wife Bessie (D)6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Sept. 10, 18828. AGE: Years Months Days If less than one day
60 11 23 hr. min.9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Dave13. Birthplace Russia14. Maiden Name Anna ?15. Birthplace Russia16 (a) Informant B. C. H. Records(b) Address 4940 Eastern Ave.17 (a) Burial (b) Date thereof 9-5-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Ches. Sharon
Location Trappe Rd.18 (a) Funeral director Jack Lewis Son
2100 Eutan Place19 (a) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1943 at 10 A M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 6-26 1942 to 9-3 1943
and that I last saw him alive on 9-3 1943

Immediate cause of death

Cardiac decompensation

Duration

1 wkDue to ? EmphysemaDue to Coronary artery
disorder10 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Paul Materna M.D.Address BEIT Date signed 9-3-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 5 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07870

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1100 CHURCH ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town CURTIS BAY / BALTO MD
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1100 CHURCH ST
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD J. KOWALEWSKI

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-03-2624

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 3 1943 at 9:40 A.M.

21. I certify that death occurred on the date above stated and attended deceased from SEPT 30 1943 and that I last saw him alive on Aug 30 1943

Immediate cause of death

Pulmonary Embolism
Due to Deep Vein Thrombosis
Due to trauma of the leg

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1340 1st St Date signed 9/3/43

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DET 16-1906

8. AGE: Years Months Days If less than one day
36 10 18 hr. min.

9. Birthplace BALTO MD
(town, county, and state)

10. Usual Occupation CLERK

11. Industry or business BY ORR

12. Name STEPHAN J. KOWALEWSKI

13. Birthplace BALTO MD

14. Maiden Name ZOFIA CYWINSKI

15. Birthplace POLAND

16 (a) Informant STEPHAN J. KOWALEWSKI

(b) Address 1100 CHURCH ST.

17 (a) BURIAL (b) Date thereof SEPT 6 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A.A. Co.

18 (a) Funeral director Bernard C. J. J.

(b) Address 121 E. West St

SEP 5 - 1943

G 07871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07871

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
1819 N. Bond Street
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 N. Bond Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

William Daniel Bond

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah A. Cunningham

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 30th, 1867

8. AGE: Years 76 Months 2 Days 3
If less than one day
hr. min.

9. Birthplace Baltimore

(Town, county, and state) Retired Telegrapher

10. Usual Occupation

11. Industry or business

Penn R.R.

12. Name Joseph Bond

13. Birthplace Baltimore Md.

14. Maiden Name Carolyn Wells

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Sarah A. Bond (Wife)

(b) Address 1819 N. Bond Street

17 (a) Burial (b) Date thereof Sept. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Abingdon Cemetery
Location Abingdon Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford

SEP 5 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3, 1943, to Sept 3, 1943, and that I last saw him alive on Sept 2, 1943.

Immediate cause of death

Coronary Aneurysm

Due to Hypertension

Arterio Sclerosis

Due to Chronic Glomerular Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature S. F. O. Stevens

Address 2878 Harford Rd Date signed 9.3.43

Duration

Long

Long

Long

Long

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07872

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 2424 Linden Ave.
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 8 mo.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2424 Linden Ave.
 (If rural give location)
 (e) Citizen of foreign country (Yes or No)
 If yes, name country

3 (a) FULL NAME

Blanch Siak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced wid.

- 6 (b) Name of husband or wife Frank
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - Mar. 1894

8. AGE: Years 49 Months 6 Days hr. min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Robert Bailey
 13. Birthplace Va.
 14. Maiden Name Parable Walker
 15. Birthplace Va.

- 16 (a) Informant Ollie Bailey
 (b) Address 2424 Linden Ave.

- 17 (a) Removal (b) Date thereof Sept. 5-43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Family Burial
 Location Stilleville Va.

- 18 (a) Funeral director Thom Cook Inc.
 (b) Address 1211 St Paul St

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1943, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Miliary tuberculosis of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

- (a) Date of injury _____ at _____ M.
 (b) Where did injury occur?
 (c) Did injury occur at home, on farm, industrial place, in public place? While at work?
 (d) Means of injury _____

23. Signature Howard J. Menden M.D.Date signed 9-3-43

G 07873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07873
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

(c) Cemetery or institution

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 12:45 AM

21. I certify that death occurred on the date above stated, that I attend-

ed deceased from 2:30 PM 9/3/43

and that I last saw him alive on 9/3/43

Immediate cause of death

Arterio Sclerosis

Duration

1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

SEP 5 1943

VB 150

G 07874

MJ*57205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07874

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs., 1 mo., 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. 1806 Calvert Street

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Jacob Flichman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Susanna Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 14, 1853

8. AGE:

Years

Months

Days

If less than one day

90

6

19

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Laborer - Building

11. Industry or business

Laying

12. Name ?

Flichman

13. Birthplace Md.

14. Maiden Name ?

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a)

Burial

(b) Date thereof

9/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Mary's - Maryland

Location

Baltimore

18 (a) Funeral director

William Coon

SEP 5 - 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/3 1943 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/3 1943.

and that I last saw him alive on 9/3 1943.

Immediate cause of death

Pneumonia

Coronary failure

Due to A.S. disease

Hypertension

Due to

Other Conditions

Scurvy; pul.

emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sargman

Address B C H

Date signed 9/4

Duration

2 d.

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Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied.

Correct age is especially important.

G 07875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2

3 (a) FULL NAME

Mrs. Theresa Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frances Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day

44 4 25 26 hr. min.

9. Birthplace

Balto. Md.

10. Usual Occupation

Housewife

11. Industry or business

None

12. Name

John Kierhaus

13. Birthplace

Germany

14. Maiden Name

Frances Kierhaus

15. Birthplace

Germany

16 (a) Informant

Frances Roberts

(b) Address 233 N. Fulton Ave

17 (a)

Burial

(b) Date thereof

7/1/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Co. Md.

18 (a) Funeral director

William B. B. B.

(b) Address

147 St. Paul St

19 (a) Date

5-1943

(b) Registrar

H. W. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 233 N. Fulton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1943 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/1943 to 9/3/1943 and that I last saw him alive on 9/3/1943.

Immediate cause of death

Terminal Bronchitis

Pneumonia

Due to Central Nervous System

Due to Arteriosclerosis

by arteriosclerosis of the coronary arteries

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Limited to head Massive Central Hemorrhage

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature Richard J. Bude

Address Bon Secours Hosp.

Date signed 9/3/43.

Duration

24 hrs.

Due to

3 days

Due to

?

PHYSICIAN

Underline the cause to which death should be charged stat-
istically.

07876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07876

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
Baltimore, Md.
- (b) Street address
- (c) Hospital or institution:
South Baltimore General Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Balto. Highlands
(If outside city or town limits, write RURAL and give town)
- (d) Street No. Annapolis Rd., Delaware Avenue.
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

HARRY SACKS

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 215-05-3853

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Marie M. Sachs

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

00815, 1897

8. AGE:

Years

Months

Days

If less than one day

45

10

19

hr.

min.

9. Birthplace

Balto.

(Town, county, and state)

10. Usual Occupation

Pipefitter Standard

11. Industry or business

Wholesale & phosphate trade

12. Name

Edward Sachs

13. Birthplace

Balto. Md.

14. Maiden Name

Theresa Holmes

15. Birthplace

Balto. Md.

16 (a) Informant

Marie M. Sachs Wife

(b) Address

4805 Annapolis Rd

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Sept 7, 1943

(c) Cemetery or crematory

Geddes Hill

Location

Anne Arundel

18 (a) Funeral director

G. Howard Evans

(b) Address

1400 N. B. Harbor

EP 5-1843

(Date rec'd by registrar)

H. H. Williams

MEDICAL CERTIFICATION

9:10 A.

20. DATE OF DEATH September 4, 1943, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wollenweber M.D.

Date signed 9-8-43

G 07877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07877
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Eva Greshner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

Unknown

8. AGE:

Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace

Balt. Md.
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Charles Greshner

13. Birthplace

Germany

14. Maiden Name

Susan Summers

15. Birthplace

Balt. Md.

16 (a) Informant

Edward Greshner

(b) Address

428 N. Cross Street

17 (a)

Burial

(b) Date thereof

9/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western

Location

Baltimore, Md.

18 (a) Funeral director

F. J. G. & J. G. G.

(b) Address

1426 N. High St.

P 5-1943

(Date filed by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(c) City or town

Baltimore

(d) Street No. 428 N.

(If outside city or town, write RURAL and give town)

Cross Street

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-3-

1943, at 9⁴⁵ AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to

her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Howard

Maldeis M.D.

Medical Examiner.

Date signed 9-3-43

G 07878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07878
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2316 Aiken St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2316 Aiken St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3 (a) FULL NAME

Salvador P. Mas.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife Anna L. Selby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1890

8. AGE: Years Months Days If less than one day
53 7 7 hr. min.

9. Birthplace Larado Texas

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Md. Drydocks

12. Name not known

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Anna L. Mas.

(b) Address 2316 Aiken St.

17 (a) Burial (b) Date thereof 9/6/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

5-1943
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1943

21. I certify that death occurred on the date above stated, that I attend-
ed deceased from 9/2 1943 to 9/4 1943,
and that I last saw him alive on 9/3 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury Imp. S. Blum

23. Signature

Address 1206 E. Lombard St. Date signed 9/4/43

Physician

Sullivan

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07879

T.N

81781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07879

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 819 S. Potomac St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Anna Cummings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Elijah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1905

8. AGE: Years Months Days If less than one day

38

5

27

17

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Benjamin Huber

13. Birthplace Maryland

14. Maiden Name Margaret Merkida

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 9/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location O. Donnell St.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

SEP 5 - 1943

(Date rec'd by Registrar)

(b) *Hamilton Williams M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1943 at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/4 1943

and that I last saw him alive on 9/4 1943

Immediate cause of death

Advanced pulmonary T.B.C.

Duration

2 yr.

Due to

Due to

Other Conditions Adv. T.B.C. enteritis & laryngitis

(Include pregnancy within months of death)

Date of operation

Major findings of operations:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

B. C. H.

Date signed 9/4

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G 07880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07880

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Eleanor Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 28 1918

8. AGE:

Years 24

Months 11

Days 3

If less than one day

hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Ice Man

11. Industry or business

FATHER

12. Name

Richard Morris

13. Birthplace

?

MOTHER

14. Maiden Name

Margaret Wiley

15. Birthplace

?

16 (a) Informant

Eleanor Morris

(b) Address

1715 Mosher street

17 (a)

Buried

(b) Date thereof

Sept 5, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arlington Memorial

Location

18 (a) Funeral director

Mrs Kate R. Williams

(b) Address

322 N. Schroeder St

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1715 Mosher street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-6-1943

at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Ruptured Heart

Due to

Other Conditions

Ruptured liver

Fractured ribs, Hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-1-43 at 8:05 P.M.

(b) Where did injury occur Highway at Edmondson Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work? No

(d) Means of injury Collision 2 Ton automobiles

23. Signature Howard J. Williams M.D.

Date signed 9-3-43

881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH

CITY OF BALTIMORE No.

422 N. Carey

St.

Ward

Registered No.

(If death occurred in a hospital or institution, give its NAME (instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds.

Long in U. S. If of foreign birth? yrs. mos. ds.

FULL NAME

Sarah M. Hardy

If U.S. Veteran

Specify WAR

(a) Residence: No.

422 N. Carey

St.

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX *Female* 4. Color or Race *Cd.* 5. Single, Married, Widowed, or Divorced (write the word) *Married*

6a. If married, widowed, divorced HUSBAND of (or) WIFE of *Louis Hardy*

6. DATE OF BIRTH (month, day, year) *Apr 1911*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
82 yrs 5

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Domestic work.*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Lenoir County North Carolina*
(State or country)

13. NAME *Amos Mosley*

14. BIRTHPLACE (city or town) *Lenoir County N. Carolina*
(State or country)

15. MAIDEN NAME *Sarah Mosley*

16. BIRTHPLACE (city or town) *Lenoir County N. Carolina*
(State or country)

17. INFORMANT *Amos Mosley Jr.*
(Address) *707 E. Lenox St. Kinston, N.C.*

18. BURIAL, CREMATION, OR REMOVAL *Shelby P. H. P.*
Place *Kinston N.C.* Date *9/5/43*

19. UNDERTAKER *Mrs. Kate R. Williams*
(Address) *522 S. Schroeder St.*

20. FILED

Washington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *9/2/43*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 25* to *Aug 2*

I last saw *her* alive on *Sept 2* Death is said to have occurred on the date stated above, at *11 P. M.*

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Date of onset
8/1

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

J. D. Julian Jr.

M. D.

(Address)

511 S. Schiller St.

OCCUPATION IS VERY IMPORTANT. See instructions on back of certificate.

SEP 5 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-83132 07882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

469
G 07882
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo. 24days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1251 Myrtle Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George W. Brice

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
M

5. Color or race
C

6 (a) Single, married, widowed, or
divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25-1892

8. AGE: Years 71 Months 4 Days 9 7 hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George W. Brice

13. Birthplace Mich.

14. Maiden Name Martha Hall

15. Birthplace Canada

16 (a) Informant Balt. City Hosp.

(b) Address Baltimore Md.

17 (a) Burial (b) Date thereof Sept. 6, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. J. M. Hall

19 (a) (Date rec'd by registrar) 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1943 at 6:05 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8-9 1943 to 9-2 1943
and that I last saw him alive on 9-2 1943

Immediate cause of death

Carcinoma of Pancreas
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: above

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Donald P. Jones

Address Balt. City Hosp

Date signed 9-4-43

Duration

5 mos

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07883

MJ-83300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07883

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1721 Druid Hill Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Alice Stewart

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

colored

6 (a) Single, married, widowed, or
divorced. Separated

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 11, 1883

8. AGE: Years Months Days If less than one day

60

4

22

hr.

min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edward Thomas

13. Birthplace Virginia

14. Maiden Name Elizabeth Dorman

15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sept. 3, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Baltimore, Md.

18 (a) Funeral director Mrs. E. W. Hill

(b) Address 1631 Druid Hill Ave.

SEP 5 - 1943

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1943, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/17 1943, to 9/3 1943.
and that I last saw her alive on 9/3 1943

Immediate cause of death

embolus as pulmonary

Due to A.S. C.V. disease

Due to

Other Conditions Gen. arteriosclerosis

St. Hemiplegia

(Include pregnancy within months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary embolus

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

2. Signature

F. L. Serpman

Address

B C N

Date signed 9/4

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07884

JL - 82828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07884

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 11

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 573 Prentiss St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Augustus Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1873

8. AGE: Years Months Days If less than one day

70

3

25 days

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation Inable to work

11. Industry or business

12. Name Augustus Fields

13. Birthplace Va.

14. Maiden Name Mary Page

15. Birthplace Va.

16 (a) Informant B. G. H. Records

(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Sept. 8, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 5 - 1943

(Date received by registrar)

(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-1943 to 9-4-1943, and that I last saw him alive on 9-4-1943

Immediate cause of death.

Due to Uremia
Carcinoma of bladder

Due to Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Baltimore Hosp Date signed 9-4-43

Duration

1 wk

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 67885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 67885

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.)

8 AGE:

Years

Months

Days

If less than one day

9 Birthplace

10 Usual Occupation

11 Industry or business

FATHER

12 Name

MOTHER

13 Birthplace

14 Maiden Name

15 Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

18 (b) Address

18 (c) Date

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City

town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 2 1943, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1943, to 9/2 1943, and that I last saw him alive on 9/2 1943.

Immediate cause of death

Hypertensive Cardiac Disease

Duration

1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 07886

BALTIMORE CITY HEALTH DEPARTMENT

G 07886

CERTIFICATE OF DEATH

Registered No.

PERSONS WHOSE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 5 1943

VS 154

Washington, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07887
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1802 N Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 N Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Amelia Zinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, country, and state)

10. Usual Occupation

11. Industry or business House Work

12. Name Hersh Block

13. Birthplace Russia

14. Maiden Name Rebecca Leah

15. Birthplace Russia

16 (a) Informant Simon Herman

(b) Address 1802 N Smallwood St

17 (a) Burial (b) Date thereof Sept 6, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 SEP 6-1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-43 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Sept 4 1943 and that I last saw him alive on Sept 4 1943

Immediate cause of death

Central hemorrhage

Due to fatal overexhaustion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [Signature] Address 2904 Restwood Date signed 9/8/43

Duration

4 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

07888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07888
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1713 N Pulaski St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Anna Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.FemaleWhiteWidow6 (b) Name of husband or wife Late Eli.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1877

8. AGE: Years

Months

Days

If less than one day

662

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

FATHER

12. Name

Unknown

13. Birthplace

Russia

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Russia16 (a) Informant Mrs Joseph Goldstein(b) Address 1713 N Pulaski St17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept. 6, 1943
(month) (day) (year)(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave18 (a) Funeral director Sol Levinson & Bros(b) Address 1124 1126 W North Ave

SEP 6 - 1943

(b)

Henderson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1943 at 2:34 M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/24 1943 to 9/6 1943.
and that I last saw her alive on 9/6 1943.Immediate cause of death Pulmonary Haemorrhage

Duration

Due to Pulmonary Edema

Due to

Other Conditions Ca Head of Paranas

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm. P. SmithAddress Sinai HospitalDate signed 9/6/43

M. D.

RECORDS WITH PLAIN, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07889

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

78

61

07889
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS

(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1537 N. Appleton Street

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

3 (a) FULL NAME

Gizelle Baron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1887

8. AGE: Years Months Days If less than one day

56

6

18

hr.

min.

9. Birthplace N. J.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Leonard Betteheim

13. Birthplace Austria

MOTHER

14. Maiden Name Eliza ?

15. Birthplace Austria

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sept 6/4

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Zion Cem.

Location Long Island N. Y.

18 (a) Funeral director J. J. Williams & Sons

(b) Address 1124-26 W. North Ave.

SEP 6 1943

(b) H. H. Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/5

1943 at 8:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1943 to 9/5 1943

and that I last saw her alive on 9/5 1943

Immediate cause of death

Coronary failure; pass. coronary occlusion. Due to A. I. S. C. V. disease

Due to

Other Conditions

Diabetes mellitus, March 1943 (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. J. Sargman

Address

B. C. H.

Date signed 9/5

07890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07890
Registered No.

1. PLACE OF DEATH: BALTIMORE CITY.
 (a) Baltimore City, Maryland
 (b) Street address 2843 SAINT PAUL STREET.
 (c) Hospital or institution: NONE

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)(d) Street No. 2843 SAINT PAUL STREET.
(If rural, give location)(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN A OSTENDORF.

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 220-14-3148 A

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary Odellia Ostendorf

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 11, 1870

8. AGE: Years

73

Months

3

Days

23

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Manufacturing Business

FATHER

12. Name Clem Ostendorf

13. Birthplace

Germany

MOTHER

14. Maiden Name Catherine

15. Birthplace

Germany

16 (a) Informant Mrs. Mary Odellia Ostendorf

(b) Address 2843 St. Paul street

17 (a) Burial

(b) Date thereof 9/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral Director

(b) Address

SEP 6 - 1943

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 4 1943, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 6, 1942 to SEPT 4, 1943.

and that I last saw him alive on SEPT 4, 1943.

Immediate cause of death

CORONARY THROMBOSIS SEPT 4 1943

Due to

ARTERIO SCLEROSIS.

Duration

1936.

Due to

CHRONIC MYOCARDIAL DEGENERATION

Other Conditions

1936.

(Include pregnancy within months of death)

Date of operation

NONE

Major findings of operations

of autopsy: NONE.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 3013 ST PAUL ST.

Date signed 9/4/43

G 07891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07891
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert + Lexington Sts*

(c) Hospital or institution:

Mercy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *46*(e) Length of stay in Baltimore (yrs., mos., or days) *46*

3 (a) FULL NAME

Baby Leo Romanowski

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 20, 1943

8. AGE: Years

0

Months

1

Days

16

If less than one day

hr.

min.

9. Birthplace

Balti., Md.

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name

Bernard Romanowski

13. Birthplace

Md.

14. Maiden Name

MARY OSTROWSKA

15. Birthplace

Md.

16 (a) Informant

Mr. Bernard Romanowski

(b) Address

4312 S. Robinson St

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof

SEPT. 6/43

(c) Cemetery or crematory

ST. S. TANISLAUS

Location

DUNDALK AVE.

18 (a) Funeral director

Lilly and Geiler, INC.

(b) Address

403 S. WOLF ST.

SEP 6 - 1943

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town

Balti.

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4312**S. Robinson St*

(e) Citizen of foreign country?

(If rural give location)

no

(Yes or No)

If yes, name country

FRANCES A. ROMANSKI.

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept 5,*1943, at *2* P.M.21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 2* 1943, to *Sept 5* 1943, and that I last saw him alive on *Sept 5*, 1943.

Immediate cause of death

Acidosis, Reye's Fatigue

Due to

Neonatal Diarrhea Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

*Robert B. Truany*Address *Mercy Hosp*

Date signed

9/5/43

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87E

Registered No. 07892

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1617 McCulloh Street

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

AUSTIN JOHN MORGAN

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Carrie Turner

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1898

8. AGE: Years

45

Months

0

Days

28

If less than one day

hr.

min.

9. Birthplace King George Co., Va.

(Town, county, and state)

10. Usual Occupation Laborer- 5 yrs. ago

11. Industry or business --

12. Name William Morgan

13. Birthplace Virginia

14. Maiden Name Mary ?

15. Birthplace Virginia

16 (a) Informant Records, U. S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9-7-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Balto National

18 (a) Funeral director Isiah L. Brown & S.

(b) Address 123 W. North Avenue

19 SEP 6 - 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH September 3, 1943, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1943, to Sept. 3, 1943, and that I last saw him alive on Sept. 3, 1943.

Immediate cause of death Encephalopathy

Duration

Unk.

Due to Arterial hypertension

Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 9/8/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 07853

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2207 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mary A. Foley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 5 - 1887

8. AGE:

Years

56

Months

5

Days

29

If less than one day

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Barber

11. Industry or business

Self

FATHER

12. Name

Salvatore Foley

13. Birthplace

Italy

MOTHER

14. Maiden Name

Don't know

15. Birthplace

Italy

16 (a) Informant

Mary A. Foley

(b) Address

2207 Belair Road

17 (a)

Burial

(b) Date thereof

Sept 7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Balto Md

18 (a) Funeral director

William Funeral Home

(b) Address

2008 Orleans St

19

SEP 6 - 1943

(Date rec'd by registrar)

William H. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/4/43

19

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

07894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07894
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 200

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ANDREW

RANDLETT

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife Anna C. Randlett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 8, 1896

8. AGE: Years Months Days If less than one day
49 1 26 hr. min.

9. Birthplace Richmond Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business Police

12. Name Walter Randlett

13. Birthplace Va

14. Maiden Name Anna C. ?

15. Birthplace Va

16 (a) Informant Mrs Anna Randlett

(b) Address 4500 Harcourt Road

17 (a) Burial (b) Date thereof Sept 7, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto National

Location Little Gun Balto

18 (a) Funeral director William T. L. Home

(b) Address 2000 Orleans St

SEP 6 - 1943 (b) H. H. Williams, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 4500 Harcourt Rd
(If rural give location)City of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3, 1943, at 6:37 P.M.

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive Cardiovascular
Disease

Due to

Other Conditions NO

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature W. H. Williams, M.D.

Date signed 9-3-43

G 87895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 87895
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 200 W. 40th Street

(c) Hospital or institution:

Home for Invalids 13-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 11
(If outside city or town limits, write RURAL and give town)(d) Street No. 200 W. 40th Street
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Marie Woodfield

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife Samuel T. Field

deceased 6 (c) If alive, give age 18 yrs

7. Birth date of deceased (mo., day, yr.) May 29, 1876

8. AGE: Years Months Days If less than one day

67 3 5 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Columbus Park

13. Birthplace Baltimore, Md.

14. Maiden Name Maria Field

15. Birthplace Baltimore, Md.

16 (a) Informant Ina Frankfield

(b) Address 200 W. 40th Street

17 (a) Burial (b) Date thereof Sept 7 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Middlebury

Location Middlebury, Md.

18 (a) Funeral director Stewart M. Munn

SEP 6 - 1943

19 (a) (Date rec'd by registrar) H. W. Munn

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4, 1943, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1939, to Sept 4, 1943, and that I last saw her alive on Sept 5, 1943.

Immediate cause of death

Congestive Heart Failure

Due to Arteriosclerotic Cardio-

-Vascular Disease

- Pernicious Anemia

Hypertrophic Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas Conant Woff

Address 11 E. Chase St. Date signed 9/4/43

Duration
3 days

10 years

11 years

10 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07896

Registered No.

ya

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. yrs., mos., or days 1 day

(e) Length of stay in Baltimore yrs., mos., or days 2 yrs.

3 (a) FULL NAME

Mun Hom

(BENNIE DOON HOM)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Chinese

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 17, 1913

8. AGE: Years 30 Months 3 Days 18 hr min. If less than one day

9. Birthplace China

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wie Wah Hom

MOTHER

13. Birthplace China

14. Maiden Name ?

15. Birthplace China

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 9-7-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium Location
Loyram Woodlawn Md.

18 (a) Funeral director STEWART & MOWER COMPANY

(b) Address (W. F. WOODEN SQ.) 108 W. NORTH AVENUE

SEP 6 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 530 W. Franklin St.

(If rural give location)

(e) Citizen of foreign country ?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1943 at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1943 to 9-4 1943, and that I last saw him alive on 9-4 1943.

Immediate cause of death

Bleeding from Gastrointestinal tract
Prostate peptic ulcer

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Donald B. Bette

Address Pratt City, Ala.

Date signed 9-4-43

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07897

Registered No.

G 07897

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2806 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM C. TIMMISON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Bessie May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1977

8. AGE:

Years

Months

Days

If less than one day

66

4

20

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation Advertising

11. Industry or business Helsing & Siskler Co.

12. Name Frederick Timmison

13. Birthplace Baltimore

14. Maiden Name Louise Kohn

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bessie M. Timmison

(b) Address 2806 Walbrook Avenue

17 (a) Burial (b) Date thereof April 13, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director T.M. J. TINKER & SONS

Address

SEP 6 - 1943

(b) (Date rec'd by registrar)

VB 124

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1943, at 11:00 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from July 28, 1943, and that I last saw him alive on August 4, 1943.

Immediate cause of death

Arterio sclerosis
Myocardial degeneration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 2818 M. Paul Date signed 9/5/43

Duration

5 yrs

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

07898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07898
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 1335 Poplar Grove St.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. yrs., mos., or days: 16-7
- (e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1335 Poplar Grove St.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM WELLINGTON FRANKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife Annie E.

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

Aug. 2, 1900

8. AGE:

Years

Months

Days

If less than one day

84

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Fertilizer salesman

11. Industry or business

CNC

FATHER

12. Name

Franks

13. Birthplace

Va.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mrs. Mary E. Galloway

(b) Address

1335 Poplar Grove St.

17 (a)

Burial

(b) Date thereof

9/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

WOODLAWN CEM.
Woodlawn, Md.

Location

18 (a) Funeral director

WM. C. TUCKER & SONS

(b) Address

Baltimore, Md.

SEP 6 - 1943

(Date rec'd by registrar)

William Wellington Franks

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 2, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1943 to Sept 7 1943 and that I last saw him alive on Sept 1 1943

Immediate cause of death

Arteriosclerosis

Due to

Smoking

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. J. Gentry Jr.

Address

677 N. Howard St.

Date signed

9/3/43

Duration

1/2

1/2

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE CAREFULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07899

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 104 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME

CARL W. WEISSENBORN

3 (b) If veteran, name war
NONE

3 (c) Social Security Account
No. NONE

4. Sex
MALE

5. Color or race
WHITE

6 (a) Single, married, widowed, or
divorced MARRIED

6 (b) Name of husband or wife Matilda M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1894

8. AGE: Years Months Days If less than one day
48 8 19 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Tax Consultant

11. Industry or business Self

FATHER 12. Name Max F. Weissenborn

13. Birthplace Germany

MOTHER 14. Maiden Name Olga Prinke

15. Birthplace Germany

16 (a) Informant Mrs. Matilda M. Weissenborn

(b) Address 1040 N. Bentalou St.

17 (a) Burial (b) Date thereof 9/5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 SEP 6 - 1943
(Date rec'd by registrar)

Handwritten signature: *Handwritten signature*

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1943, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1943, to Sept 3 1943, and that I last saw him alive on Sept 3 1943.

Immediate cause of death

Duration

Amiotropic Lateral Sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert Scognetti M.D.
Address 1729 W. Towson Date signed 9/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07900

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2708 Biggs Ave.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *10-9*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2708 Biggs Ave.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

*Agnes C. Holland*6 (c) If alive, give age *72* years7. Birth date of deceased (mo., day, yr.) *Aug 25, 1861*

8. AGE:

Years

82.

Months

Days

10

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name

James Feeley

13. Birthplace

Ireland

14. Maiden Name

Sarah Liberty

15. Birthplace

Ireland

16 (a) Informant

Mr Agnes C. Holland

(b) Address

2708 Biggs Ave.

17 (a)

Burial

(b) Date thereof

9/8/1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park Cemetery

Location

3801 Redwood Road

18 (a) Funeral director

Wm. J. Cowan & Co.

(b) Address

901 S. Hollins St.

19 SEP 6 - 1943

(b) *Thurston Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 4, 1943* at *4 A.* M21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 4* to *Sept 4* 19*43*and that I last saw him alive on *Sept 3* 19*43*

Immediate cause of death

Chronic Cardio Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

*Ernest H. Kahn*Address *735 Poppy St*Date signed *9/6/43*

07901

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07901

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-05-8271

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Genevieve E. Mondshour

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

58

4

22

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min.

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07902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07902
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3026 Westfield Avenue

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 12, 1875

8. AGE:

Years

Months

Days

If less than one day

67

10

23

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

Thomas Preston

13. Birthplace

Baltimore, Md.

14. Maiden Name

Elizabeth M. Neal

15. Birthplace

Baltimore, Md.

16 (a) Informant

John F. Forrester

(b) Address

3026 Westfield Ave. Baltimore

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Ave

Location

4300 Old Federal Rd

18 (a) Funeral director

John F. Forrester

(b) Address

901 23rd St.

SEP 6 - 1943

(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 4, 1943, 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 1, 1943, to Sept 4, 1943

and that I last saw her alive on Sept 4, 1943.

Immediate cause of death

Myocardial Failure

Duration

1 mo.

Due to Arteriosclerotic Cardiovascular Disease

Due to Arteriosclerosis

Other Conditions Dry Gangrene of both Feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Stanley B. Klymowski

Address

St. Joseph's Hospital

Date signed

9/4/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07903
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3134 Fair Ave

(c) Hospital or institution:

Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3134 Fair Ave
(If rural give location)(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

John Felter

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-10-1088

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Catherine6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Mar 8, 1918

8. AGE: Years

65

Months

5

Days

26

If less than one day

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Molder

11. Industry or business

12. Name

John Felter

13. Birthplace

Baltimore Md.

14. Maiden Name

Mary Hoffmeyer

15. Birthplace

Baltimore Md.

16 (a) Informant

Catherine Felter

(b) Address

3134 Fair Ave17 (a) Burial

(b) Date thereof

Sept 7, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

mt Carmel Cem

Location

O'Donnell St.

18 (a) Funeral director

John J. Duda

(b) Address

2029 Hudson St.

SEP 6 - 1943

(b) Huntington Alliance

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1943 at 1:30 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from April 1943 to Sept 1943, and that I last saw him alive on Sept 4 1943.

Immediate cause of death

Due to Chronic MyocarditisDue to Chs. Bronchitis

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation noneMajor findings of operations: -of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence Sept 4 at 1:30 P. M.(c) Where did injury occur? at home (City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)(e) Means of injury J.A. Rosenblatt23. Signature J.A. RosenblattAddress 3078 O'Donnell St Date signed 9/6/43

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07904

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St.

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore

(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2708 Berle Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

PATRICIA NOVAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female W.

5. Color or race

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (b) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-43

8. AGE: Years 2 Months 15 Days 15 If less than one day
hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Frank J. Novak

13. Birthplace Baltimore Md.

14. Maiden Name Agnes Kenderyska

15. Birthplace Baltimore Md.

16 (a) Informant Frank Novak

(b) Address 2708 Berle Ave

17 (a) X (b) Date thereof 9-7-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Lynch St

18 (a) Funeral director John J. Huda

(b) Address 2829 Hudson St

SEP 6 - 1943 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-1943 at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-1943 to 9-5-1943, and that I last saw her alive on 9-5-1943

Immediate cause of death Dehydration

Due to Diarrhea & vomiting

Due to

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. B. Ballma

Address St. Joseph's Hosp. Date signed 9/5/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07905
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1934 Hollins

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr 5 1883

8. AGE:

Years

Months

Days

If less than one day

90

4

29

29

hr.

min.

9. Birthplace

Baltimore Md

10. Usual Occupation

None

11. Industry or business

12. Name

Wm. Smith

13. Birthplace

Germany

14. Maiden Name

W. T. S. S. S. S.

15. Birthplace

Germany

16 (a) Informant

Mrs. Robert M. S. S.

(b) Address

1934 Hollins

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

9-6-43

(c) Cemetery or crematory

Fulton Park

Location

Baltimore Md

18 (a) Funeral director

Fulton & S. S.

(b) Address

Fulton & S. S.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1934

Hollins

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 19 43, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 42 to Sept 19 43, and that I last saw him alive on Sept 3 19 43.

Immediate cause of death

Pulmonary C.V. Disease

Due to

Due to

Other Conditions Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 5217 Patton Rd Date signed 9/3/43

SEP 6 - 1943

02906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 02906
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or place of interment

18 (a) Funeral director

(b) Address

19

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-5-43

19

9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4-43 19 to 9-5-43 19.

and that I last saw her alive on 9-5-43 19.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

9-5-43

Physicians who sign this certificate, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07907

MASSAK
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G 07907
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 423 S. Wolf St

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yr

3 (a) FULL NAME

Mrs. Mary Massar

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-05-5314

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife Emrich Massar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years Months Days If less than one day

49

hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Michael Szafarz

13. Birthplace Poland

14. Maiden Name Magdalena Sz

15. Birthplace Poland

16 (a) Informant Husband

(b) Address 423 S. Wolf St. Balt Md.

17 (a) Burial (b) Date thereof 9-7-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Baltimore, Md.

18 (a) Funeral director George R. Weber

(b) Address 705 So. Ann Street

SEP 6 - 1943

VB 140

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 423 S. Wolf St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1943 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 28 1943 to Sept 4 1943, and that I last saw him alive on Sept 4 1943.

Immediate cause of death

Cardio-Respiratory Failure

Due to Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Marcus L. Adelschmidt M.D.

Address Mercy Hosp. Date signed 7/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 07909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82 ✓ 6 07909
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(d) Street No. 448 W. Belknap
(If outside city or town, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Brown Savage (alias Johnson)
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex J. 5. Color Cl. 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife James Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1900
8. AGE: Years 43 Months 7 Days 3 If less than one day hr. min.

9. Birthplace Charles County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Philip Martin
13. Birthplace Md.
MOTHER 14. Maiden Name Annie Washington
15. Birthplace Md.

16 (a) Informant James Johnson
(b) Address 448 W. Belknap

17 (a) (Burial, cremation, or removal) Calvary
(b) Date thereof Sept 6 1943
(month) (day) (year)
(c) Cemetery or crematory Location

18 (a) Funeral director H. H. H. H.
19 (a) (Date rec'd by registrar) SEP 8 1943

MEDICAL CERTIFICATION
20. DATE OF DEATH 9-2 1943 at 3:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1943 to 9-2 1943
and that I last saw her alive on 9-2 1943

Immediate cause of death
Respiratory Failure
Due to Bulbar Paralysis
Due to Brain Stem Tumor??
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Brain fixed in study.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas B. Wenne
Address Univ. Hospital Date signed 9/2 D.

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

6 87910

JL - 83134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

139a

Registered No. 6 87910

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

3 (a) FULL NAME

Josie Womack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1903

8. AGE: Years

40

Months

3

Days

27

If less than one day

hr.

min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Elwood Artley

13. Birthplace

N. C.

MOTHER

14. Maiden Name

Isabelle Megle

15. Birthplace

N. C.

16 (a) Informant B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9-7-43

(month) (day) (year)

(c) Cemetery or crematory

Not Calvary

Location

18 (a) Funeral director

Adolphus Halstead

18 (b) Address

918 Druid Hill Ave.

18 (c) Date rec'd by registrar

SEP 6 - 1943

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 536 Oxford St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-3

1943 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1943 to 9-3 1943, and that I last saw him alive on 9-3 1943

Immediate cause of death

Due to

Peritonitis
Bilateral Tubo-ovarian
Abscesses

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

8-26-43

Major findings of operation:

Above

of autopsy:

above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Dorcas B. Webb

Address

Baltimore City Hosp

Date signed

9-4-43

07911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07911
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3 N. East Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3 N. East Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.3 (a) FULL NAME John Dougherty

3 (b) If veteran, name war

no3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 19098. AGE: Years Months Days less than one day
32 34 11 4 24 hr. min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual Occupation

Laborer.

11. Industry or business

FATHER
MOTHER

12. Name

Senge. A. Dougherty

13. Birthplace

Baltimore Md.

14. Maiden Name

Mary Senge

15. Birthplace

Baltimore Md.

16 (a) Informant

Senge. A. Dougherty

(b) Address

3 N. East Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Cath. Lawn

Location

Eastview ave.

18 (a) Funeral director

Heidell. Shippel

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1943, at 11:15 AM21. I certify that I took charge of the remains described above, held an
Autopsy & Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema

Due to

Other Conditions Chronic Myocardial Degeneration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Howard J. Mulderis M.D.
Medical Examiner.Date signed 9-3-43

SEP 6 1943

07912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07912

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 805 Melville Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Frederick W Blaser

(BIASER)

3 (b) If veteran, name war

-

3 (c) Social Security Account

No. 074-01-3482

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Anne (nee) Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sep 19, 1912

8. AGE:

Years

Months

Days

If less than one day

30

11

17

hr.

min.

9. Birthplace

New York

(Town, county, and state)

10. Usual Occupation

Asst General Foreman

11. Industry or business

Glenn L. Martin Co.

FATHER

12. Name

Frederick P. Blaser

13. Birthplace

Unknown

MOTHER

14. Maiden Name

Evangeline Huber

15. Birthplace

Unknown

16 (a) Informant

Mrs. Frederick Blaser

(b) Address

805 Melville Ave.

17 (a) Removal

(b) Date thereof

Sept 7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Bridgeport Conn.

18 (a) Funeral director

Harry H. Witzke

(b) SEP 6 - 1943

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-5-

1943, at 5:10 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Crushed Chest

Bilateral Pneumo Thorax

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-5-43 at 8:30 P. M.

(b) Where did injury occur Balto. Co. Lookout tower, Cedar Beach

(c) Did injury occur at home, on farm, industrial place, in public

place? Public While at work? Yes

(d) Means of injury Fell from steps of tower

23. Signature Howard J. Walden M.D.

Date signed 9-5-43 Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07913

WRIGHT
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 935

G 07913
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19. Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attended deceased from 8/16/1943 to 9/1/1943 and that I last saw him alive on 8/31/1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07914
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md

(b) County Haward.

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 6 - 1943

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw h - alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

07915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07915
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

20 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Neil Seim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/4/43

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Ferman J. Seim

13. Birthplace

Baltimore Md.

14. Maiden Name

Thelma R. Connelly

15. Birthplace

Baltimore Md.

16 (a) Informant

Ferman J. Seim

(b) Address

306 S. Pulaski St.

17 (a)

Burial

(b) Date thereof

9-7-43
(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore, Md.

18 (a) Funeral director

L. W. Schwalbe

19 (a)

SEN 7-1943
(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(d) Street No.

306 S. Pulaski St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/6

1943

at 4:30 M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 9/5 1943 to 9/6 1943

and that I last saw him alive on 9/6 1943

Immediate cause of death

Intracranial hemorrhage?

Due to

Due to

Other Conditions

Persistent cyanosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. Cohen

Address

University Hosp

Date signed

9/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

07917

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2402 Roslyn Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HARRY SHANE SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife. Mary A. Bockmiller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 12, 1877

8. AGE: Years

66

Months

1

Days

22

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Sewing

12. Name Charles H. Scott

13. Birthplace Baltimore, Md.

14. Maiden Name Kate Shane

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary A. Scott

(b) Address 2402 Roslyn Ave.

17 (a) Burial

(b) Date of burial 9/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Greenwood Cemetery

Location Hager Rd., Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

SEP 7 - 1943

(Date received by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1943, to Sept 4, 1943, and that I last saw him alive on Sept 3, 1943.

Immediate cause of death

Bronchopneumonia

Due to

Cerebral
hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edward J. Harsman

Address

4037 Falls

Date signed 9/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07918

MARDAQA
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07918
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from to and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

57919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 57919
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5720 Ridgdale Rd

(c) Hospital or institution: Mt. Washington

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

3 (a) FULL NAME

John Marks

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband/wife

Christine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 18658. AGE: Years Months Days If less than one day
78 6 24 hr. min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual Occupation

Proprietor

11. Industry or business

Hotel

FATHER

12. Name Gerhardt Marks

13. Birthplace Germany

MOTHER

14. Maiden Name Hedra Jensen

15. Birthplace Germany

16 (a) Informant Marie T. Marks

(b) Address 5720 Ridgdale Rd

17 (a) Burial (b) Date thereof 9/7/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Woodlawn

Location

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 SEP 7 - 1943 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 5720 Ridgdale Rd
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4th 1943 10³⁰ A.M.21. I certify that death occurred on the date above stated; that I attended deceased from August 15, 1942, to Sept 4th, 1943, and that I last saw him alive on Sept 4th, 1943.

Immediate cause of death

Coronary Atherosclerosis

Due to Coronary Atherosclerosis

Due to Coronary Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury B.S. Moore

23. Signature B.S. Moore M.D.

Address 76 Calhoun St. Date signed 9/6/43

Duration

192 days

2 yrs

about

3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

67920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67920

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3019 Independence St

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Manning Storey

3 (b) If veteran, name war

3 (c) Social Security Account

No.

NONE

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

divorced

Male

White

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1943

8. AGE:

Years

Months

Days

If less than one day

6

29

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Charles M. Storey

13. Birthplace

Knoxville, Tenn.

MOTHER

14. Maiden Name

Marie Luvall

15. Birthplace

New York, N. Y.

16 (a) Informant

Mrs. M. Storey

(b) Address

3019 Independence St

17 (a) Burial

(b) Date thereof

9/8/43

(c) Cemetery or crematorium

Moulton Park

Location

Baltimore, Md.

18 (a) Funeral director

William Fox Inc.

(b) Address

1217 St. Paul St.

19

SEP 7 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/5

1943, at 12:00 M

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Infantile Diarrhea

Due to

Other Conditions

(Include pregnancy within 5 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. McElly, M.D.

Date signed

9/6/43.

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

07921

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4107 Granite Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2109 E. Orleans
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 213-10-3405

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Malinda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 27, 1885

8. AGE:

Years

Months

Days

57 11 8

hr.

min.

9. Birthplace

Brooklyn, New York

10. Usual Occupation

Asbestos Worker

11. Industry or business

Waller + Hale

12. Name

Chas Daffin

13. Birthplace

14. Maiden Name

Alice Kelly

15. Birthplace

16 (a) Informant

Lorora Simers

(b) Address

4107 Granite Ave

17 (a) Burial

(b) Date thereof Sept 8, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodland

Location

Baltimore City

18 (a) Funeral director

Wm. C. Clark, Inc.

(b) Address

St Paul + Preston

19 SEP 7 - 1943

Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 - 1943 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2, 1943 to Sept. 5, 1943 and that I last saw him alive on Sept. 5, 1943.

Immediate cause of death

Pneumonia Pulmonalis

Duration

5 yrs

Due to

Due to

Other Conditions Chronic Myocarditis 5 yrs

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm. C. Clark, Inc.

Address 1613 E. North Ave.

Date signed

G 07922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07922

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4131 Hayward Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 2 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4131 Hayward Ave.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Rebecca Berryman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Ephraim Berryman

6 (c) If alive, give age and years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1856

8. AGE: Years Months Days If less than one day

87

0

109

hr.

min.

9. Birthplace Reisterstown Balt. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name Mr. Alford Constantine

13. Birthplace Reisterstown, Md.

14. Maiden Name Zenobia Parrish

15. Birthplace Balt. Co.

16 (a) Informant Mary Berryman Dunbar

(b) Address 4131 Hayward Ave. Balt.

17 (a) Burial (b) Date thereof Sept 8, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Mr. Berryman + Sons

(b) Address Reisterstown, Md.

19 (a) (b)

(Date rec'd by registrar)

Registrar

SEP 7 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/6

1943, 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to Sept 1943

and that I last saw her alive on 9/5/1943

Immediate cause of death

Cerebral edema

Due to

Arterio sclerosis

Due to

Ages

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 4710 Liberty Rd. Date signed 9/6/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07923
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2431 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

3 (a) FULL NAME

Ruth C Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Frank M Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 14, 1877

8. AGE: Years Months Days

66

2

31

If less than one day

hr.

min.

9. Birthplace

Rock Hall Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

same

FATHER

12. Name

Singleton, Thomas Hayden

13. Birthplace

Baltimore Md

MOTHER

14. Maiden Name

Mary Crouch

15. Birthplace

Rock Hall Md

16 (a) Informant

Jill Richardson

(b) Address

2431 Edmondson Ave

17 (a)

Burial

(b) Date thereof

Sept 9, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Linden Park

Location

18 (a) Funeral director

Chas P Towell

(b) Address

2431 Edmondson Ave

19 (a)

SEP 7 - 1943

Hester Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2431 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1943, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-43 19 to 9-5-43 19

and that I last saw her alive on 9-4-43

Immediate cause of death

Uremia

Duration

Due to

arteriosclerotic kidney disease

Due to

chronic arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

Signature

Harry L. Lintel

Address

2703 Edmondson

Date signed 9-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓
93NG 07924
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 240 N. Payson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 240 N. Payson St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNA E. NIXON

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed6 (b) Name of husband or wife Edward L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/19128. AGE: Years Months Days If less than one day
70 8 6 hr. min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual Occupation Manager of Lunch Rooms11. Industry or business Dan & Elmer Co.12. Name Guida13. Birthplace unknown14. Maiden Name Lucile15. Birthplace unknown16 (a) Informant Mrs. Willard Owens(b) Address 240 N. Payson St.17 (a) Burial (b) Date thereof 9/8/43
(Burial, cremation, or other) (month) (day) (year)(c) Cemetery or crematory London PK.
Location Dalto - Ind's18 (a) Funeral director Wm. J. Lickner & Son(b) Address North 19 Ave.19 SEP 7 - 1943 Washington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1943 at 12:50 M21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

arteriosclerotic
cardiovascular
Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature H. W. Allen M.D.Date signed 7-6-43 Allen Medical Examiner.

6 07925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07925
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4613 Parkheights Ave**
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) **3**
(e) Length of stay in Baltimore (yrs., mos., or days) **53 Yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **25 S Exeter St**
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Etta Alper

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.**Widow**6 (b) Name of husband or wife **Late Boris**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1871

8. AGE: Years

72

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

FATHER

12. Name **Jacob ?**13. Birthplace **Russia**

MOTHER

14. Maiden Name **Unkown**15. Birthplace **Russia**16 (a) Informant **Mrs Flora Sly**(b) Address **25 S Exeter St**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Sept. 7, 1943**

(month) (day) (year)

(c) Cemetery or crematory **Hebrew Washington Road**Location **Washington Blvd**18 (a) Funeral director **Sol Levinson & Bros**(b) Address **1124 1126 W North Ave****SEP 7 - 1943**

(Date filed by Registrar)

(b) **William M. Williams**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 6, 1943, at 8 P.M.**21. I certify that death occurred on the date above stated; that I attended
deceased from **Sept 4, 1943** to **Sept 5, 1943**,
and that I last saw him alive on **Sept 5, 1943**.

Immediate cause of death

Basal carcinoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? **While at work?**

(Specify type of place)

(e) Means of injury

23. Signature **A. H. Hornstein**Address **733 Lexington St** Date signed **9/9/43**

07926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07926
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Hilkey & Caban Cres*
(c) Hospital or institution *St Agnes*
(d) Length of stay in hospital or inst. (year, month, or days) *11/3*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Balls Bluffs*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *814 Heavens Lane*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Max Cohen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex *Male* 5 Color or race *White* 6 (a) Single, married, widowed, or divorced *Widowed*
6 (b) Name of husband or wife *Late Rebecca*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1876*
8. AGE: Years *67* Months Days If less than one day hr. min.

9. Birthplace *Russia*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Philip Cohen*
13. Birthplace *Russia*
14. Maiden Name *Leop*
15. Birthplace *Russia*

16 (a) Informant *Superintendent*
(b) Address *St Agnes Hosp*

17 (a) *Burial* (b) Date thereof *Sept 7/43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Balto Hebrew Cmt*
Location *Blair Road*

18 (a) Funeral director *Sal L. Linnson & Bros*
(b) Address *134-26 N. North Ave*
SEP 7 - 1943 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 6* 19*43*, at *3:05 P.* M

21. I certify that death occurred on the date above stated; that I attended deceased from *8-26* 19*43* to *9-6* 19*43* and that I last saw him alive on *9-6* 19*43*

Immediate cause of death

Myocardial infarct
Due to *Hypertensive C.V.D.*
Due to *aggravated by*
hypertension
Renal calculi

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature *Alfred L. Linnson*
Address *St Agnes Hosp.* Date signed *9-6-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07927
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4941 Belair Road
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 7(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5114 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Martin C. W. Bergstraesser

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 507-07-2715

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1943, at 8⁵⁵ P.M.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Hilda Bergstraesser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. April 22, 18928. AGE: Years 51 Months 4 Days 15 If less than one day
14 hr. 14 min.9. Birthplace Helena, Nebraska
(Town, county, and state)10. Usual Occupation Manager11. Industry or business New Deal Tavern12. Name Geplartt Bergstraesser13. Birthplace Germany14. Maiden Name Carolyn Schot15. Birthplace Nebraska16 (a) Informant Hilda Bergstraesser(b) Address 5114 Belair Road17 (a) Removal (b) Date thereof 9/8/43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Lincoln, Nebraska18 (a) Funeral director David H. Blight Jr.(b) Address 4914 Belair Road19 (a) 1943 (b)21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury _____ at _____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?
(d) Means of injury _____23. Signature Robert Lee Graham M.D.Date signed Sept. 7 1943

SEP 7 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

a 1375
G 07928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07928

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State M.D. (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 525 N MOUNT ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOYCE ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female Colored

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1937

8. AGE: Years Months Days If less than one day

6 2 13 hr. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name JAMES ROBINSON

13. Birthplace N.C.

14. Maiden Name MAY

15. Birthplace N.C.

16 (a) Informant RECORDS

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 8, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory 9th Auburn Cem.

Location

18 (a) Funeral director Mr. Harry R. Williams

(b) Address 232 N. Howard St.

19 (a) SEP 7 1943 (b) Register

MEDICAL CERTIFICATION

20. DATE OF DEATH SEP. 5 1943 4:38 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-43 to 9-5-43 and that I last saw him alive on 9-5-43

Immediate cause of death

Myocardial

Due to thrombolytic infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-4-43

Major findings of operations Removal of spleen

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry R. Williams

Address Johns Hopkins Hop Date signed Sept 6, 43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3133 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1704 N. Carrollton Ave.

(e) Citizen of foreign country? 605 M. Hoffmann (Yes or No)
If yes, name country

3 (a) FULL NAME

John Nelson

5258

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

black

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1886

8. AGE:

Years

Months

Days

If less than one day

57

0

14

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

janitor

11. Industry or business

FATHER
MOTHER

12. Name

Joseph

13. Birthplace

N.C.

14. Maiden Name

Dianna Stewart

15. Birthplace

N.C.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a)

Burial

(b) Date thereof

Sept. 9, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Schroeder St.

19 (a)

SEP 7 - 1943

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1943 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/43 to Sept. 4 1943, and that I last saw him alive on Sept. 4 1943.

Immediate cause of death

Duration

Pulmonary tuberculosis

8 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Sengman

Address

13 C.H.

Date signed

9/5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07930
930 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 936 Shields Pl.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Belle Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

12. Name William Jones

13. Birthplace Essex Co. Va.

14. Maiden Name Amanda Taylor

15. Birthplace Essex Co. Va.

16 (a) Informant Julia Sapp

(b) Address 936 Shields St.

17 (a) Burial (b) Date thereof Sept 7-43

(c) Cemetery or crematory Mt. Auburn Cem.

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 936 Shields St.

19 (a) SEP 7-1943

19 (b) Address

19 (c) Address

19 (d) Address

19 (e) Address

19 (f) Address

19 (g) Address

19 (h) Address

19 (i) Address

19 (j) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1943, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1943, to Sept 1 1943, and that I last saw him alive on Sept 1 1943.

Immediate cause of death

Hypertensive Heart Disease

Due to

Due to

Arteriosclerosis

Other Conditions Congestive Failure.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature G. H. B. B. B.

Address

Date signed Sept 13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07931
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 1336 W Lombard St
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 19
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1336 W Lombard St
 (If rural give location)
 (e) If foreign born, how long in U. S. A? _____ years

3 (a) FULL NAME

Charles Masulis (Masendukas)

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-10-3025

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Varonika

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE: Years Months Days If less than one day

61 hr. min.

9. Birthplace

Lith
(town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Varonika Masendukas(b) Address 1336 W Lombard St17 (a) Burial (b) Date thereof Sept 8 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer
Location Blair Rd18 (a) Funeral director Joseph Kasimovskas & Co(b) SEP 7 1943 Washington Bldg19 (a) (Date rec'd by registrar) Sept 7 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH SEP 5 1943 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1943 to Sept 5 1943 and that I last saw him alive on Sept 4 1943.

Immediate cause of death Chronic
Congestive heart failure
Emphysema, chronic

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following: NO

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. J. MelanAddress 600 Washington St Date signed Sept 7 1943

Duration
1 year
3 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 07932
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *Green + Lombard St*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *18*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County
(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *44 Parkin St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *YAZIS WAITU KARTIS (White)*

3 (b) If veteran, name war *L* 3 (c) Social Security Account No. *215-07-2475*

4. Sex *male* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *married*

6 (b) Name of husband or wife *Anna* 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1882*

8. AGE: Years *60* Months Days If less than one day hr. min.

9. Birthplace *Lith*
(Town, county, and state)

10. Usual Occupation *Tailor*

11. Industry or business

12. Name *P*

13. Birthplace *Lith*

14. Maiden Name *P*

15. Birthplace *Lith*

16 (a) Informant *Anna Waitukartis*
(b) Address *44 Parkin St*

17 (a) *Burial* (b) Date thereof *9/9/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer Church*
Location *Blair Rd*

18 (a) Funeral director *Joseph Kasmakos Inc*
(b) Address *602 N. Cal. Bldg*

19 *SEP 27 1943* (b) *Robert L. Williams*
Approved: *Robert L. Williams M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-6-1943* at *1:50 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9-6-1943* to *9-6-1943* and that I last saw him alive on *9-6-1943*

Immediate cause of death *Heart failure*

Due to *Coronary occlusion*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *W.R. Jenkins*

Address *University Hosp.* Date signed *9-6-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07933
Registered No. 93d

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 5201 North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret B. Krastel

3 (b) If veteran, name was

3 (c) Social Security Account
No. —

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Peter J. Krastel

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1866

8. AGE: Years 77 Months — Days 6 less than one day
hr. min.

9. Birthplace Balto, Co. md
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

12. Name Frank Haisknecht

13. Birthplace Germany

14. Maiden Name ✓

15. Birthplace ✓

16 (a) Informant Mrs Margaret Clark

(b) Address 5201 North Ave

17 (a) Burial (b) Date thereof 9-7-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore md

18 (a) Funeral director Leonard J. Kusch

(b) Address 5305 Holston Rd

19 (a) SEP 7 - 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to 9/4 1943 and that I last saw her alive on 9/4 1943

Immediate cause of death Myocardial Infarction

Cardiovascular

Heart

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury Myocardial Infarction

23. Signature W. B. Kelly

Address 5703 Keyport Rd signed 9/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439772
G 07934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07934
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Arnold
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Kruz
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Martha 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-72
8. AGE: Years 70 Months 11 Days - If less than one day hr. min.

9. Birthplace Litch. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

12. Name Martin Kruz
13. Birthplace Litch.
14. Maiden Name Mary
15. Birthplace Litch

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-8-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard G. Runk
(b) Address 305-17441 Road

19 (a) SEP 7-1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1943 at 11:05 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1943 to Sept 5 1943 and that I last saw him on Sept 5 1943.

Immediate cause of death
CONGESTIVE HT. FAILURE

Due to

Due to

Other Conditions TBC. of RT. lung

(Include pregnancy within 3 months of death)

Date of operation Sept. 1, 1943

Major findings of operation:
LIGATION PULMONARY ARTERY

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John B. Frensch

Address Johns Hopkins Hosp Date signed SEP 7 1943

G 07935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07935

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1800 Blk Monument St*

(c) Hospital or institution:

 Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3144 Ravenwood Dr*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Eva B. Ward

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. *None*

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or

Married

6 (b) Name of husband or wife

Hugh M. Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 7, 1904

8. AGE: Years

39

Months

4

Days

22

hr.

min.

If less than one day

9. Birthplace

Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

at Home

12. Name

William S. Thompson

13. Birthplace

Baltimore Co. Md.

14. Maiden Name

Pearl S. Hilgert

15. Birthplace

Baltimore Co. Md.

16 (a) Informant

Mr. Hugh M. Ward

(b) Address

*3144 Ravenwood Dr*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Sept. 9, 1943

(month) (day) (year)

(c) Cemetery or crematory

Mt. Carmel M. L. Cemetery

Location

Mt. Carmel Balto. Co. Md.

18 (a) Funeral director

Charles W. Conklin & Son

(b) Address

924 E. Eager St.

19 (a)

(Date rec'd by registrar)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 5, 1943*, at *11:30 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug. 17, 1942* to *Sept. 5, 1943*, and that I last saw her alive on *Sept. 5, 1943*.Immediate cause of death *Cardiac Failure*

Duration

Due to *Hypertensive C. V. D.*Due to *Renal insufficiency*Other Conditions *CPC of lungs; anemia*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Henry M. M. D.*Address *Sinai Hosp.* Date signed *9-5-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 7 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07936
Dr. Jacob Schmidt
2924 Brighton Street

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07936
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **1106 Poplar Grove Street**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **74 yrs.**

3 (a) FULL NAME

George W. Miller

- 3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Widower**

- 6 (b) Name of husband or wife **Clementine Miller**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 25, 1869**
8. AGE: Years **74** Months **2** Days **11** hr. **10** min.

9. Birthplace **Baltimore, Maryland**
(Town, county, and state)

10. Usual Occupation **Foreman (DeVed & Sons)**
11. Industry or business **Sashweights**

- FATHER
12. Name **Charles Miller**
13. Birthplace **Germany**
MOTHER
14. Maiden Name **Fredericka Kipp**
15. Birthplace **Germany**

- 16 (a) Informant **Lula V. DeVed**
(b) Address **1106 Poplar Grove Street**

- 17 (a) **Burial** (b) Date thereof **Sept. 8, 1943**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory **Loudon Park**
Location **Baltimore, Maryland**

- 18 (a) Funeral director **Harry H. Hunsch**
(b) Address **4204 Ridgewood Ave.**

- 19 (a) **SEP 7 1943** (b) **Frederickton Williams**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
(c) City or town **Baltimore Md.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1106 Poplar Grove Street**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 5 - 1943** at **M**

21. I certify that death occurred on the date above stated; that I attended deceased from **March 1943** to **Sept. 5 1943**, and that I last saw him alive on **Aug. 16 1943**.

Immediate cause of death

Carcinoma of Tongue

Duration
About one year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature **J. E. Schmidt** M. D.
Address **2924 Brighton Street** signed

G 07937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1907 Alleana St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1907 Alleana St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPH

GRUNSKI

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-09-1046

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1909

8. AGE: Years Months Days If less than one day
34 45 15 4 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Joseph Grunski

13. Birthplace Poland

MOTHER

14. Maiden Name Wladyslawa Das

15. Birthplace Poland

16 (a) Informant Mrs Wladyslawa Kurowski

(b) Address 1907 Alleana St

17 (a) Burial (b) Date thereof Sep 7 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Church

Location Baltimore County

18 (a) Funeral director John M. Welby

(b) Address 401 S. Chester Street

19 (a) Registrar

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1943 at 6 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Vascular heart disease, mitral
insufficiency, rheumatic basis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Was an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Wollemacher M.D.

Date signed 9-4-43 Medical Examiner.

SEP 7 - 1943

07938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07938
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

922 N. Gilman St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

50 yrs

3 (a) FULL NAME

Sophia Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Benjamin Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 23-1875

8. AGE:

Years

Months

Days

If less than one day

67

11

11

hr.

min.

9. Birthplace

Charleston W Va

10. Usual Occupation

House work

11. Industry or business

at home

FATHER

12. Name

Washington Coates

MOTHER

13. Birthplace

Md

14. Maiden Name

Martha Gress

15. Birthplace

Md

16 (a) Informant

Mrs. Octavia Gray

(b) Address

825 N. Gilman St

17 (a)

Burial, cremation, or removal

Burial

(b) Date thereof

Sept 29-43

(c) Cemetery or crematory

Brooks Chapel

Location

Calvert Co. Md

18 (a) Funeral director

Sam'l H. Chase

(b) Address

638 N. Gilman St

SEP 7 - 1943

VS 186

Fluoridation William M. D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(d) Street No.

922 N. Gilman

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 5

1943

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

my heart

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

07939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH131a ✓ G 07939
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *20-1*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME:

George Bordley

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

*Negro*6 (a) Single, married, widowed, or
divorced.*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 15, 1879

8. AGE:

Years

Months

Days

If less than one day

*64**5**20*

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

George Bordley

13. Birthplace

MD

14. Maiden Name

Minerva ?

15. Birthplace

MD

16 (a) Informant

Geneva M. Barnes

(b) Address

1403 Jefferson St

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

9/8/43

(month) (day) (year)

(c) Cemetery or crematory

Mt. Carey Cem.

Location

A. A. County, Md.

18 (a) Funeral director

Joseph K. Rocks

(b) Address

364 N. Central Ave

19 (a)

SEP 7 - 1943

(Date rec'd by registrar)

Frederick Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) Street

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1403 Jefferson St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9-5-*19*43*, at *10* *5* A M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: ☒ natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Howard J. Mullein

M.D.

Date signed *9-5-43*

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07940
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1466 North Carey Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph Marsell Kyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 3, 1943

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER

12. Name Joseph Kyler

13. Birthplace Maryland

MOTHER

14. Maiden Name Vashti Roberson

15. Birthplace Maryland

16 (a) Informant Hospital records

(b) Address Johns Hopkins Hospital

17 (a) Burial (b) Date thereof Sept 8-1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 9 1943

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1943, 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1943 to Sept. 5, 1943, and that I last saw him alive on Sept. 5, 1943.

Immediate cause of death Atelectasis

Questionable congenital heart disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. P. Phelan

M. D.

Address Johns Hopkins Hospital Date signed 9-7-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07941
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1509 E. Fairmount Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Lillian Beale

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Female

5. Color or race
Colored

6 (a) Single, married, widowed, or
divorced. **Married**

6 (b) Name of husband or wife **Albert Beale**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **July 29, 1897**

8. AGE: Years Months Days If less than one day
46 1 5 hr. min.

9. Birthplace **Northumberland Co., Va.**
(Town, county, and state)

10. Usual Occupation **Domestic**

11. Industry or business

12. Name **Eli Davis**

13. Birthplace **Va.**

14. Maiden Name **Julia Beale**

15. Birthplace **Va.**

16 (a) Informant **Pearl Beale**

(b) Address **1509 E. Fairmount Ave.**

17 (a) **Burial** (b) Date thereof **9/7/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Calvary**
Location

18 (a) Funeral director **Elroy O. Wilson**

(b) Address **1000 Brantley Ave.**

SEP 7 1943 **Washington Williams**
VS 114

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **1509 E. Fairmount Ave.**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/4 1943 6 P. M.**

21. I certify that death occurred on the date above stated, that I attend-
ed deceased from **3/30 1943** to **9/4 1943**
and that I last saw him alive on **9/4 1943**

Immediate cause of death **Acute**

Mileage **Tuberculosis** **6 mo.**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **abdominal mass**

Major findings of operations **Mileage**

of autopsy **John H. H. H.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Dr. Williams**

Address **1509 E. Fairmount Ave.** Date signed **9/6/43**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

440676

07942

71

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07942
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louisa Moll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 31 1875

8. AGE:

Years

Months

Days

If less than one day

71

6

8

5

4

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Fredrick Westerman

13. Birthplace

Md

14. Maiden Name

Louisa ?

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 8/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Balto Cem

Location

Balto Md

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2008 Orleans St

19

SEP 7 - 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5347 Lakewood

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 5 1943 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 3 1943 to Sept 5 1943

and that I last saw her alive on Sept 5 1943

Immediate cause of death

Infarction of

right cerebral hemisphere

Duration

Due to

thrombus from

Due to

chronic auricular fibrillation

Due to

arteriosclerotic C-V disease

Other Conditions

diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John R Birmingham

Address

J. H. H.

Date signed

9-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07943		BALTIMORE CITY HEALTH DEPARTMENT		6 07943	
CERTIFICATE OF DEATH		a3d		Registered No.	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:			
(a) Baltimore City, Maryland		(a) State <u>Ind.</u> (b) County <u>Baltimore</u>			
(b) Street address <u>116 S. Highland St.</u>		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)			
(c) Hospital or institution:		(d) Street No. <u>116 S. Highland St.</u> (If rural give location)			
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country? <u>No</u> (Yes or No)			
(e) Length of stay in Baltimore (yrs., mos., or days) <u>66 yrs.</u>		If yes, name country			
3 (a) FULL NAME <u>ANNA ELIZABETH HORST</u>					
3 (b) If veteran, name war		3 (c) Social Security Account			
<u>No</u>		<u>No. None</u>			
4. Sex <u>Female</u>	5. Color or race <u>white</u>	6 (a) Single, married, widowed, or divorced <u>widowed</u>			
(b) Name of husband or wife <u>John Thomas Horst</u>		6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>August 12, 1877</u>					
8. AGE: Years <u>66</u>	Months <u>--</u>	Days <u>25</u>	If less than one day <u>24</u> hr. min.		
9. Birthplace <u>Baltimore</u> (Town, county, and state)					
10. Usual Occupation <u>Housewife</u>					
11. Industry or business					
12. Name <u>Ewald Rose</u>					
13. Birthplace <u>Germany</u>					
14. Maiden Name <u>Amelia Hoffman</u>					
15. Birthplace <u>Germany</u>					
16 (a) Informant <u>Clinton Horst (son)</u>					
(b) Address <u>3426 Jomeway</u>					
17 (a) <u>Burial</u> (b) Date thereof <u>9/15/43</u> (Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory <u>St. Pauls 5th Ref.</u> Location <u>Baltimore, Maryland</u>					
18 (a) Funeral director <u>Henry Sander & Sons, Inc</u>					
(b) Address <u>North Ave. & Broadway</u>					
Date rec'd by <u>Sept 7-1943</u> Registrar <u>Washington Williams, M.D.</u>					
MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>Sept. 6</u> 19 <u>43</u> at <u>2004</u>					
21. I certify that death occurred on the date above stated; that I attended deceased from <u>1942</u> to <u>Sept. 6</u> 19 <u>43</u> and that I last saw her alive on <u>Sept. 5</u> 19 <u>43</u>					
Immediate cause of death <u>Pneumonia</u> <u>Uremia</u>					
Due to <u>Hypertensive cardiac</u> <u>vascular disease</u>					
Other Conditions <u>Atherosclerosis</u>					
(Include pregnancy within 3 months of death)					
Date of operation					
Major findings of operation:					
of autopsy:					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at <u>M</u>					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?					
(e) Means of injury					
23. Signature <u>C. F. Richter</u>					
Address <u>513 Chelan St.</u> Date signed <u>9/6/43</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07944

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Santa Rosa*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 month 24 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *7*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *C & C*

(c) City or town *Mayo Md*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Laura M. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No. *✓*

4. Sex

F

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE:

Years

Months

Days

If less than one day

75

hr.

min.

9. Birthplace

Mayo, Cal to Ind
(Town, county, and state)

10. Usual Occupation

housewife

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *Mercy Hospital Record*

(b) Address *Baltimore Md.*

17 (a) *Burial*

(b) Date thereof *Sept 9 1943*
(month) (day) (year)

(c) Cemetery or crematory *Hope Chapel*

Location *Edgewater Md*

18 (a) Funeral director *T. A. Harshbarger & Co*

(b) Address *Baltimore Md*

19 (a) *SEP 7 1943*

(b) *Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 7 1943* at *6 A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *July 13 1943* to *Sept 7 1943* and that I last saw *her* alive on *Sept. 7 1943*.

Immediate cause of death

Cardiac respiratory failure

Due to

Coronary & Hypertensive
Failure & Transverse aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *9/23/43*

Major findings of operations: *Coronary*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *J. R. Squire*

Address *Mercy Hospital* Date signed *9/7/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07945
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5*

(e) Length of stay in Baltimore (yrs., mos., or days) *LIFE*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *410 MYRTLE BALTIMORE*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *410 MYRTLE AVE.*
(If rural give location)

(e) If foreign born, how long in U. S. A.

3 (a) FULL NAME

Dorothy Richardson (BUNCH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *3-22-1929*

8. AGE: Years Months Days If less than one day
14 5 15 hr. min.

9. Birthplace *BALTIMORE Md.*
(Town, county, and state)

10. Usual Occupation *SCHOOL*

11. Industry or business

12. Name *CARL RICHARDSON*

13. Birthplace *Md.*

14. Maiden Name *LILLYS B RICHARDSON*

15. Birthplace *Md.*

16 (a) Informant *LILLYS B RICHARDSON*

(b) Address *410 MYRTLE AVE*

17 (a) *Burial* (b) Date thereof *9-9-53*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *MT. AUBURN CEM.*
Location *BALTIMORE Md.*

18 (a) Funeral director *William A Jackson*

(b) Address *916 Pembroke Ave*

19 (a) *SEP 7 - 1953* (b) *Washington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-6-43* 19*43*, at *4:54 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9-4-43* 19*43*, to *9-6-43* 19*43*, and that I last saw her alive on *9-6-43* 19*43*.

Immediate cause of death

respiratory failure

Due to *Tetanus*

Due to *(none)*

Other Conditions

(Include pregnancy within 8 months of death)

Major findings: *none*

Of operations

Of autopsy *none*

Duration
5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Margaret Smith*

Address *Sydenham Hosp.* Date signed *9/6/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

07946
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1510 E. Hoffman St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME

Heintz Herman (Jack) Ludwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Dorothy Ludwig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Jan 24th 1906

8. AGE:

Years

Months

Days

If less than one day

37

7

12

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Bartender

11. Industry or business

Grasser

12. Name

(Unknown) Ludwig

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant Dorothy Ludwig

(b) Address 1510 E. Hoffman St.

17 (a) Burial (b) Date thereof 9/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Balt. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) (b) Registrar

SEP 7 - 1943

Approved: Robert Lee Graham M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6-43 19 at 5:38 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-43 to 9-6-43 and that I last saw him alive on 9-6-43

Immediate cause of death

Intestinal Obstruction

Due to

Diaphragmatic Hernia

Due to

Old Bullet Wound

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-4-43

Major findings of operations Diaphragmatic

Hernia & obstruction

of autopsy: same as above.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Stanley B. Kliganowicz

Address St. Joseph's Hospital Date signed 9-2-43

Duration

5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

490
G 07947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos., 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town, write RURAL and give town)
(d) Street No. 445 V. ELLWOOD AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES KAVANAUGH-KAVANAGH
3 (b) If veteran, name war
3 (c) Social Security Account No. L

4. Sex MALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced WIDOWER
6 (b) Name of husband or wife HANORAH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 1-1876
8. AGE: Years 67 Months 7 Days 3 If less than one day hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation RETIRED
11. Industry or business COPPER-SMITH

12. Name Patrick Kavanagh
13. Birthplace Ireland
14. Maiden Name Cath. Leary
15. Birthplace Laurel, MD

16 (a) Informant James Kavanagh
(b) Address 2934 E. Fayette St
(c) Cemetery or crematory location Old Frederick Rd
(d) Date thereof 8-43
(e) Date thereof (month) (day) (year)

17 (a) Burial, cremation, or removal
(b) Date thereof (month) (day) (year)
(c) Cemetery or crematory location Old Frederick Rd
(d) Date thereof (month) (day) (year)

18 (a) Funeral director John A. Moran
(b) Address 4001 Greenmount Ave
(c) Date thereof (month) (day) (year)

19 (a) SEP 7-1943
(b) Date thereof (month) (day) (year)

20. DATE OF DEATH 9-4-1943, at 8:25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5-24-1943 to 9-4-1943, and that I last saw him alive on 9-4-1943.
Immediate cause of death cerebral thrombosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Kavanagh
Address St. Joseph's Hosp Date signed 9-4-43

PHYSICIAN
Underline the cause to which death should be charged statistically.

VB 180

07948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07948
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 876 Washington Blvd
- (c) Hospital or institution:
Doctors Hospital
- (d) Length of stay in hospital or inst. (yrs., mo., or days) 2
- (e) Length of stay in Baltimore (yrs., mo., or days) 2

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ma. (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1319 W. Fayette St.
(If rural give location)
- (e) If foreign born, how long in U. S. A? _____ years

3 (a) FULL NAME

Boy (twin "B") of Hobert and Marion Jastes

3 (b) If veteran, name war

3 (c) Social Security Account

No. -----

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife.

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 9-2-43

8. AGE:

Years

Months

Days

If less than one day

-

-

2

hr.

min.

9. Birthplace Baltimore, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Hobert Jastes

MOTHER

13. Birthplace Lafayette, Tennessee14. Maiden Name Marion Darlene Cook15. Birthplace Wellersburg, Pa.16 (a) Informant Dr. Louis J. Glass(b) Address 876 Washington Blvd

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 7 1943
Commissioner of Health

18 (a) Funeral director

(b) Address

SEP 7 - 1943
(Date Noted by Registrar)(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1943 at 5 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-1943 to 9-4-1943, and that I last saw him alive on 9-4-1943.

Immediate cause of death

anoxia and convulsions

Duration

Due to intracranial hemorrhage

Due to

Other Conditions virtuweight 2108.15 oz.

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Louis J. Glass

M. D.

Address 876 Washington Blvd signed 9-4-43

07949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07949

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1119 Briscoe Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Maggie Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

45

hr.

min.

9. Birthplace

?

(Town, county, and state)

10. Usual Occupation

?

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b)

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-1-

1943

at 9:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Violent means

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Thomas J. Mulderio

M.D.

Date signed 9/1/43

Medical Examiner.

17950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07950
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 831 P. Bow Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1866

8. AGE: Years Months Days If less than one day

77

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 7 1943

18 (a) Funeral director

Commissioner of Health

19 (a)

(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2-1943 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cordis - vascular thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Wolskel M.D.

Medical Examiner.

Date signed 9-3-43

0344

07951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07951
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1522 S. Charles

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1522 S. Charles St.

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Walter Richard McAllister

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/1867

8. AGE: Years Months Days If less than one day

76

3

25

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Stevedore

11. Industry or business

State

FATHER
MOTHER

12. Name

Richard V. McAllister

13. Birthplace

Md

14. Maiden Name

Margaret A O'Neill

15. Birthplace

Ireland

16 (a) Informant

Miss Marie P. Rudolph

(b) Address

1522 S. Charles St.

17 (a)

Burial

(b) Date thereof

9/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Old Superior Rd.

18 (a) Funeral director

J. J. Light

(b) Address

1318 Light St.

19 (a)

(Date rec'd by registrar)

Walter McAllister

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1943 to 9/6 1943 and that I last saw him alive on 9/6/43 19

Immediate cause of death

Cancer of jaw & throat

Duration

6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: me

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. J. White M.D.

Address 1279 Indiana St. Date signed 9/14/43

SEP 7-1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

In. Vol. 532
4710 Liberty High

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6 07952
830a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address. 3520 N. Hieton Road

(c) Hospital or institution:

Washburn Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 W 38th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George H. Morrison.

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

male white

white

widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

Julia G. Morrison

7. Birth date of deceased (mo., day, yr.)

Nov 28, 1856

8. AGE:

Years

Months

Days

If less than one day

86

9

8

hr.

min.

9. Birthplace

Maryland

10. Usual Occupation

Retired.

11. Industry or business

Store Keeper.

12. Name

Robert Morrison.

13. Birthplace

Maryland

14. Maiden Name

Elizabeth ?

15. Birthplace

Maryland

16 (a) Informant

Samuel W. Morrison

(b) Address

5702 Edmondson Ave

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Pleasant Hill

Location

Bolts Co. Md.

18 (a) Funeral director

Chenoweth & Son

19 (a) Filed

15-17 6th St

SEP 7 1943

(Date rec'd by registrar)

William

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1943 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1943 to Sept 6 1943

and that I last saw him alive on Sept 6 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

3 days

Due to

arteriosclerosis

Due to

hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

L. J. Volquik

23. Signature

Address 4710 Liberty St

Date signed 9/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07953

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07953
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-07-7741

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Duration

3 wks.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

N/A.

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 07954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07954

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore(c) City or town Maryland Line
(If outside city or town limits, write RURAL and give town)(d) Street No.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edward Thompson13. Birthplace Md. Line, Md.

MOTHER

14. Maiden Name Ruth Sparks15. Birthplace Freeland, Md.16 (a) Informant Mrs. Lizzie Thompson(b) Address Md. Line, Md.17 (a) Burial (b) Date thereof SEPT 8/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory PINE GROVELocation BALTO. CO. MD.18 (a) Funeral director Jacob Mortenson(b) Address West Freedom, Pa.19 (a) SEP 7 1943 (b) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEP 9/43 1943 at 12:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943 to 9/5 1943, and that I last saw him alive on 9/4 1943.

Immediate cause of death

Respiratory failure
+ shockDue to sub-arachnoid
hemorrhageDue to injury at birthOther Conditions - deaf

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature J. S. JellAddress Van. HospitalM. D.
Date signed 9/5

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

07955

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07955

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 132 da

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 128 E. Montgomery St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Servando Santa-Juana

81069

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1908

8. AGE: Years Months Days If less than one day

35

6

23

hr.

min.

9. Birthplace

Phillipines

(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

FATHER
MOTHER

12. Name

Philip Mochide

13. Birthplace

Phillipines

14. Maiden Name

Seferana Santa-Juana

15. Birthplace

Phillipines

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sep 8/43

(month) (day) (year)

(c) Cemetery or crematory

Location

Sacred Heart of Mary
Baltimore County

18 (a) Funeral director

(b) Address

John M. Weber
404 S. Chester Street

19 SEP 8 - 1943

(State and by)

Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1943 3:30P M

21. I certify that death occurred on the date above stated; that I attended
deceased from Aug. 20 1943 Aug. 30 1943
and that I last saw him alive on Aug. 30 1943

Immediate cause of death

Duration

Pulmonary tuberculosis

1 1/2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(a) Means of injury

23. Signature

E. L. Sargman

Address

BCH

Date signed

9/7

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07956
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3630 Malden Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 3630 Malden Ave
(If rural give location)(e) Citizen of foreign country? Yes or No
If yes, name country.

3 (a) FULL NAME

James Albert Gordon

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of deceased's wife

Ella Gordon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26th 18618. AGE: Years 82 Months 1 Days 11 If less than one day
hr. min.9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual Occupation Retired Carpenter11. Industry or business Building12. Name Daniel Gordon13. Birthplace Frederick Co. Md.14. Maiden Name Elizabeth Wolf15. Birthplace Md16 (a) Informant Mrs Ella Gordon(b) Address 3630 Malden Ave17 (a) Burial (b) Date thereof 9/10/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory WesternLocation Balto Md.18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul19 (a) SEP 10 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1943 4:27 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to Sept 7 1943 and that I last saw him alive on Sept 7 1943

Immediate cause of death

Cardiac vascular disease.Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James J. [Signature]Address 846 W 36 St Date signed 9/17/43Duration 9 wks.10 yrs 3

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly.

62957

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 62957

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1713 Barnes St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Johanna Rhames

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

N hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Robert Driggs

13. Birthplace Piquette, Michigan

14. Maiden Name Almira Stewart

15. Birthplace Maryland

16 (a) Informant mother

(b) Address 1027 N. Caroline St.

17 (a) (b) Date thereof 9-8-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Baltimore Ind.

18 (a) Funeral director Leticia Gross

(b) Address 1408 Ashland Ave

19 SEP 8 - 1943 (b) Huntington Williams, M.D.

Date signed by

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1943 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1943 to Sept 4 1943.

and that I last saw her alive on Sept 4 1943.

Immediate cause of death

Postpartum Hemorrhage

Due to uterine inertia

Ruptured Uterus?

Other Conditions Face Presentation over

(Include pregnancy within 3 months of death)

Date of operation Sept 4 1943 Forceps Extraction

Major findings of operations

of autopsy: not granted

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury by Gun

23. Signature J. H. Barnes

Address Proctor Hospital

Date signed 9-8-43

Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07958

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to Sept 6, 1943, and that I last saw him alive on Sept 6, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Date signed

VB

G 07959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 07959

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

108 N. Hilton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

23 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

108 N. Hilton St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Rose L. Daniels

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Charles M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 9, 1894

8. AGE:

Years

Months

Days

If less than one day

48

9

26

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

George Lusk Laugh

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Emma Bowyer

15. Birthplace

West Virginia

16 (a) Informant

Th. Charles M. Daniel

(b) Address

108 N. Hilton St.

17 (a)

Burial

(b) Date thereof

9/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Morland Mem. Park

Location

Baltimore Md.

18 (a) Funeral director

Henry H. Witzke

(b) Address

4101 Edmondson Ave.

19 (a)

(b) by registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 4

1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1943, to Sept. 4, 1943, and that I last saw her alive on Sept. 4, 1943.

Immediate cause of death

Uremia

Due to

Chronic nephritis

Due to

Other Conditions

Cirrhosis of liver

Pleural Effusion - Probable carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William F. Pearce

Address

2105 N. Charles St.

Date signed

9/7/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 8 - 1943

G 07960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G 07960

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 322 E. 25th St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

IDA S. MATHIAS

3 (b) If veteran, name war

--

3 (c) Social Security Account
No. --

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife Elmer E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1862

8. AGE: Years

81

Months

4

Days

20

If less than one day

hr.

min.

9. Birthplace York Co., Pa.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Peter Lauer

13. Birthplace York Co., Pa.

14. Maiden Name Savina Raffensberger

15. Birthplace York Co., Pa.

16 (a) Informant Mrs. Daisey E. Eicker

(b) Address 322 E. 25th St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/9/43

(month) (day) (year)

(c) Cemetery or crematory Manchester Union

Location

Manchester, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a)

SEP 8 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 E. 25th St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1943 at 7:30 AM

21. I certify that death occurred on the date above stated that I attend-
ed deceased from Feb 1942 to Sept 6 1943.
and that I last saw her alive on Sept 5, 1943.

Immediate cause of death

Cerebral arteriosclerosis

Duration

6 mo

Due to old age.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 2706 St Paul

Date signed

M. D.

9/7/43

Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

G 07961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07961

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40TH ST.

(c) Hospital or institution:

Home for Incubables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 2 mo. 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) ~~subd.~~ (b) County

(c) City or town Baltimore - 11

(If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40TH ST.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Mary E. Lyover

3 (b) If veteran, name

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced

Widowed

6 (b) Name of husband or wife Daniel James Lyover

6 (c) If alive give age — years

7. Birth date of deceased (mo., day, yr.) 11/30/1861

8. AGE:

Years

Months

Days

If less than one day

82

7

6

hr.

min.

9. Birthplace Warrenton, U.C.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Mr. Daniel Dugger

13. Birthplace Brunswick Co., Va.

MOTHER

14. Maiden Name Rebecca Hucks

15. Birthplace King William Co., Va.

16 (a) Informant Home for Incubables Records

(b) Address 700 W. 40TH ST.

17 (a) Burial (b) Date thereof 9/8/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. John's C.

Location Wagerly, Balto. Md.

18 (a) Funeral director Wm. J. Trehan

(b) Address Balto., Md.

19 (a) Date of death 9/6/43

19 (b) Place of death Home for Incubables

19 (c) Date of death 9/6/43

19 (d) Place of death Home for Incubables

19 (e) Date of death 9/6/43

19 (f) Place of death Home for Incubables

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 - 1943, 3:04 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept. 4, 1943, to Sept. 6, 1943

and that I last saw him alive on Sept. 4, 1943.

Immediate cause of death

Atherosclerotic Cardiovascular Disease

with Acute Myocardial Infarction

Chronic Bronchitis

Old ununited fracture left

hip joint

Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas Conrad Wyl

Address 11 E. Chase St

Date signed 9/6/43

Duration

10 years

5 minutes

3 years

9 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

25 years

Correct age as especially important. Physicians: please write the causes of death clearly and legibly.

G 07962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07962

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 902 Beaumont Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 902 Beaumont Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY BRICE ELPHINSTONE

3 (b) If veteran, name war
none3 (c) Social Security Account
No.4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife Henry C. Elphinstone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1892

8. AGE: Years Months Days If less than one day
50 9 0 hr. min.9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual Occupation Ass't. Treas.

11. Industry or business D.C. Elphinstone Co., Inc.

12. Name James Tilden

13. Birthplace Maryland

14. Maiden Name Mary Pitts

15. Birthplace Va.

16 (a) Informant Mrs. Beatrice E. Benton

(b) Address 1604 Ralworth Rd.

17 (a) Burial (b) Date thereof 9/8/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date of death (b) Signature of Registrar
SEP 8 1943 (c) Signature of Informant

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1943 at 11:30 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 6 1943 to Sept. 5 1943
and that I last saw her alive on Sept. 5 1943.

Immediate cause of death

Carcinoma Lungs,
Liver, stomach
Due to Carcinoma left breast

Duration

2 yrs.

4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Carl H. Benson, M.D.

Address 511 York Rd. Date signed Sept. 7, 1943

Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

G 07963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07963

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 760 Vine Street
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 760 Vine Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Richard Boston

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1865

8. AGE:

Years

Months

Days

If less than one day

78

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

None

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name George M. Boston13. Birthplace Md.14. Maiden Name Harriet Butler15. Birthplace Md.16 (a) Informant Mrs Sarah L. Dorsey(b) Address 760 Vine Street17 (a) Burial (b) Date thereof 9-9-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. AlbansLocation Baltimore, Md.18 (a) Funeral director Francis A. Hensley(b) Address 278 W. Biddle St.SEP 8 - 1943 (b) Address Huntington Williams(b) Address Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, '43 1943 at 2:50 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1943 to Sept 6 1943 and that I last saw him alive on Sept 6 - 1943.

Immediate cause of death

Chronic myocarditis

Due to

Due to

Other Conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edw. J. WheatleyAddress 1220 S. Hill Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 07964
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2921 N. Calvert St.
(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3 (a) FULL NAME Henry S. King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Ella Wynn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1849

8. AGE: Years 93 Months 8 Days 12 If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Henry S. King

13. Birthplace Baltimore, Md.

14. Maiden Name Susan Smith

15. Birthplace Baltimore, Md.

16 (a) Informant Edward S. King

(b) Address Riderwood, Maryland

17 (a) Burial (b) Date thereof 9/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location - 3801 Frederick Ave., Balto.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1906 Eutan Place

19 SEP 8 - 1943 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 19 43 at 9:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 19 43 to Sept 6 19 43, and that I last saw him alive on Sept 3, 19 43.

Immediate cause of death - Pulmonary embolism

Due to Atherosclerotic heart disease & coronary artery

Due to fibrillation

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theron Harrison

Address 16 E. Biddle St.

Date signed 9/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07965

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 428 N. Lakewood Ave.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 6
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 428 N. Lakewood Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mary E. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced widowed
 6 (b) Name of husband or wife John M.
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1881

8. AGE: Years 62 Months 45 Days hr. min.
 If less than one day

9. Birthplace Baltimore
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

12. Name William J. Birmingham13. Birthplace Ireland14. Maiden Name Anna Brady15. Birthplace Ireland16 (a) Informant William J. Murphy16 (b) Address 428 N. Lakewood Ave.17 (a) burial (b) Date thereof 9/9/43
(Burial, cremation, or removal) (month) (day) (year)17 (c) Cemetery or crematory New Cathedral
Location Frederick Rd.18 (a) Funeral director M. W. K. Deppel & Sons18 (b) Address Lombard & Ann St.19 (a) SEP 8 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1943, at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. P. 1943, to Sept 6 1943, and that I last saw him alive on Sept 4 1943.

Immediate cause of death

Carcinoma of left breast with 8 metsDue to Carcinoma left mammae 10/11/43

Due to

Other Conditions Myocardial degeneration 8/4.

(Include pregnancy within 3 months of death)

Date of operation March 1943Major findings of operation: Carcinoma of left mammae

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. T. RiceAddress 24 S. My Date signed Sept 7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G 07966

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4204 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Roland Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Carrie B. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

- 4 Sex Female 5 Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas B. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21-1875

8. AGE: Years 68 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(City, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name Levi Chambers

13. Birthplace Maryland

14. Maiden Name Mary Holland

15. Birthplace Maryland

16 (a) Informant Thomas B. Davis

(b) Address 4204 Roland Ave.

17 (a) Burial (b) Date thereof Sept 9-1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Surge's Funeral Home

(b) Address 3631 Falls Road

19 (a) Date of death Sept 6-1943

(b) Time of death 8:15 P.M.

20. DATE OF DEATH Sept 6-1943 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1943 to Sept 6 1943, and that I last saw him alive on Sept 6 1943.

Immediate cause of death: Carcinoma of Esophagus

Duration 14 1/2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6-1943 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1943 to Sept 6 1943, and that I last saw him alive on Sept 6 1943.

Immediate cause of death:

Carcinoma of Esophagus

Duration 14 1/2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 846 W 36th St Date signed 9/7/43

SEP 8 1943

VS 144

120358 Light 36
G 07967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07967

Registered No.

92B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2720 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna Beda Tuckerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife George H. Tuckerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8 - 1892

8. AGE: Years 90 Months 9 Days 28
If less than one day hr. min.

9. Birthplace Balto., Ind.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Luther Riepe

13. Birthplace Germany

14. Maiden Name Mulderman

15. Birthplace Unknown

16 (a) Informant Mrs. Estelle Tuckerman

(b) Address 2720 Reisterstown Rd. McFE

17 (a) Cremation (b) Date thereof Sept. 9 - 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Linden Park Cem
Location Baltimore

18 (a) Funeral director Mamie Cook Super

(b) Address 1600 W. North Ave

19 (a) SEP 8 - 1943 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1943, at 5:58 P

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1/43 1943 and that I last saw him alive on 19

Immediate cause of death

Heart Failure

Due to

Due to

Other Conditions

High Blood Pressure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John D. Holt M. D.

Address 1234 N. 1st St. Baltimore Date signed 9/6/43

Duration

Primary
Myocardial
Infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

1. Write the cause of death clearly and legibly.

07968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07968

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1943, to Sept 7 1943, and that I last saw him alive on Sept 7 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Address

Date signed

In case of death, please write the causes of death clearly and legibly.

SEP 8 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07969

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert + Saratoga Dr*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 mos*

(e) Length of stay in Baltimore (yrs., mos., or days) *1 mo*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baets.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1000 Darley Ave*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Helma Eileen Schuler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 16, 1883*

8. AGE: Years Months Days If less than one day

0

3

24

21

hr.

min.

9. Birthplace

Baets, Md

(Town, county, and state)

10. Usual Occupation

Superintendent

11. Industry or business

12. Name

Charles Schuler

13. Birthplace

Baets, Md

14. Maiden Name

Mary Seymour

15. Birthplace

Baets, Md

16 (a) Informant *Mrs Charles Schuler*

(b) Address *1000 Darley Ave*

17 (a)

B.

(b) Date thereof *9-9-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Wheaton Ridge

Location

Washington Bldg.

18 (a) Funeral director

Jas. L. McQuay

(b)

1308 E. Fort Ave.

19 (a)

8-10

(Date rec'd by registrar)

Washington Bldg.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 7, 1943* *15* *12 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *7/7* *1943*, to *8/7* *1943*, and that I last saw him alive on *8/7* *1943*

Immediate cause of death *Cardiac*

Failure

Due to

Congenital Heart Disease

Due to

Other Conditions *Gangrene, shock,*

enlarged liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Robert B. Tamm*

Address *Mercy Hosp*

Date signed *9/7/43*

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07970

YA

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07970

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 11 fr

3 (a) FULL NAME

Katherine Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Separated

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1910

8. AGE: Years

33

Months

1

Days

3

If less than one day

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Lloyd

13. Birthplace Md.

14. Maiden Name Elizabeth

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(RECORDS)

17 (a) Burial, cremation, or removal

Reburial

(b) Date thereof

9/9/43

(c) Cemetery or crematory

Location

St. Auburn

18 (a) Funeral director

(b) Address

1343 Prussman St

19 SEP 8 - 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 22 W. Lafayette Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/6

1943, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1943 to 9/6 1943 and that I last saw her alive on 9/6 1943.

Immediate cause of death

Uremia

Due to chronic glomerulonephritis & hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

as above & death occurred of autopsy: necrosis of colon

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. L. Serpman

Address

BCH

Date signed

9/7

G 07971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07971
Registered No.

AB-83629

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **4940 Eastern Ave.**
- (c) Hospital or institution:
Baltimore City Hospitals
- (d) Length of stay in hospital or inst. (yrs., mos., or days) **3 days**
- (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MD.** (b) County
- (c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
- (d) Street No. **1115 E. Pratt St.**
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Martin Finn Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 15-1892**8. AGE: Years Months Days If less than one day
51 3 21 hr. min.9. Birthplace **Baltimore, Md.**

(Town, county, and state)

10. Usual Occupation **W.W. Veteran**

11. Industry or business

12. Name **Simon Finn**13. Birthplace **Ireland**14. Maiden Name **Margaret Curtin**15. Birthplace **Ireland**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records**17 (a) **Burial** (b) Date thereof **Sept 10 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **U.S. National**
Location **Frederick Ave.**18 (a) Funeral director **Neudell Steppel**(b) Address **312 S. Highland Ave**19 (a) **SEP 8 1943** (b) **Huntington Williams, Md.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/6 1943 at 5:30 P.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **9/3 1943** to **9/6 1943** and that I last saw him alive on **9/6 1943**.

Immediate cause of death

Pulmonary T.B.C.

Duration

7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

no post

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **E. L. Sengman**Address **BCH**Date signed **9/7**

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

07972

T.N

83591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07972
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 617 N. Carrollton

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Girl Johnson (Gloria

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

C

6 (a) Single, married, widowed, or
divorced. N.B

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1943

8. AGE:

Years

Months

Days

If less than one day

1

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Frederick Johnson

13. Birthplace Maryland

MOTHER

14. Maiden Name Gloria Reeder

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a)

(b) Date thereof 9/7/43 at 9:

(month) (day) (year)

(c) Cemetery or crematory

Baltimore, City Hospi

Location 4940 Eastern Ave., Baltimore,

18 (a) Funeral director

(b) Address

19

SEP 8 - 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1943, at 12:00

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-2 1943 to 9-2 1943.

and that I last saw her alive on 9-2 1943.

Immediate cause of death

Congenital Atelectasis

Duration

7 day

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation. none

Major findings of operation:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Baltimore City Hosp. - Date signed 9-2-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07973
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calhoun & Fayette*(c) Hospital or institution: *Franklin Square*(d) Length of stay in hospital or inst. (yrs., mo., or days) *6 1/2*

(e) Length of stay in Baltimore (yrs., mo., or days)

3 (a) FULL NAME

Nellie E. Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

*married*6 (b) Name of husband or wife *Clarence Elmer Bull*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 11, 1880*8. AGE: Years *62* Months *11* Days *27* 26 hr. min.9. Birthplace *Baltimore, Md.*10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Jacob Markey*13. Birthplace *Unknown*14. Maiden Name *Margaret*15. Birthplace *Unknown*16 (a) Informant *Clarence E. Bull*(b) Address *3408 Beech Ave.*17 (a) *Burial* (b) Date thereof *Sept. 10, 1943*(c) Cemetery or crematory *Pine Grove*Location *Baltimore County*18 (a) Funeral director *Roland F. Fisher*(b) Address *5005 Park Heights Ave.*19 *SEP 8 - 1943* (b) *Huntington Williams, M.D.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. *3408 Beech Ave.*(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-7* 19*43* at *1:55* AM21. I certify that death occurred on the date above stated; that I attended deceased from *9-1* 19*43* to *9-7* 19*43* and that I last saw her alive on *9-7* 19*43*.Immediate cause of death
Myocardial infarction

Due to

Due to

Other Conditions *Myocardial failure*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *E. W. Peake*Address *4508 Harford Rd*

Date signed

M. D.

PLEASE WRITE PRINTED, WITH CORRECT AGE. PHYSICIANS: please write the causes of death clearly and legibly. correct age is especially important.

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

G 07974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07974
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **Station Hospital****Holshird Ordnance Depot, Balto, 19, Md.**(d) Length of stay in hospital or inst. (yrs., mos., or days) **10 days**(e) Length of stay in Baltimore (yrs., mos., or days) **45 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Tenn.** (b) County(c) City or town **Hendersonville**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **R.D. #2** (If rural give location)(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

3 (a) FULL NAME

Frank R. Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 12, 1917**

8. AGE: Years Months Days If less than one day

26**3****25****hr.****min.**9. Birthplace **Jackson County, Tenn.**

(Town, county, and state)

10. Usual Occupation **Soldier**11. Industry or business **U.S. Government**12. Name **A. M. Hamilton**13. Birthplace **Unknown**14. Maiden Name **Unknown**15. Birthplace **Unknown**16 (a) Informant **U.S. Army Records**(b) Address **Holshird Ordnance Depot, Md.**17 (a) **BURIAL** (b) Date thereof **SEPT. 11/43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **HENDERSONVILLE CEM.**Location **HENDERSONVILLE TENN.**18 (a) Funeral director **Lilly and Queller INC.**(b) Address **403 1/2 WOLFE ST.****8-1943**

(Date rec'd by registrar)

(b) **William Williams, M.D.**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **7 September 1943** **1:45 P.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **28 Aug. 1943** to **7 Sept. 1943**, and that I last saw **him** alive on **7 Sept. 1943**.Immediate cause of death **Intestinal obstruction with perforations small bowel.**Due to **Multiple peritoneal adhesions (old).**Due to **Appendicitis, acute, suppurative, existed prior to induction.**

Other Conditions

(Include pregnancy within 1 month of death)
Date of operation **6 September 1943**Major findings of operations: **Perforations small bowel due to old adhesions.**of autopsy: **Autopsy not performed.**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury **Shrapnel**23. Signature **A.M. Iman**Address **Holshird Ordnance Depot** Date signed **9-11-43**

Balto, 19, Md.

G 07975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07975

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *721 Kirsch's Court*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Roberta Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days *July 23, 1934*
9 1 11 hr. min.9. Birthplace *Beth. Md.*

(Town, county, and state)

10. Usual Occupation *None*

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Sept 8, 1943*
(month) (day) (year)

(c) Cemetery or crematory

Location *Mr. Calvary Cemetery*
A. A. County Md.

18 (a) Funeral director

(b) Address

SEP 8 - 1943

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-4-1943* at *8 P. M.*21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *her* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions *Fractured femur;**multiple blunt lacerations abdomen*
(Include pregnancy within 3 months of death)22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *9-4-43* at *7:39 P. M.*(b) Where did injury occur *in front of 930 Greenmount*(c) Did injury occur at home, on farm, industrial place, in public
place? *Public* While at work? *No*(d) Means of injury *Struck by street car*23. Signature *Howard J. Maldeis* M.D.
Medical Examiner.Date signed *9-5-43*

G 07976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07976
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Doctors Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 510 Calander Street

(If rural give location)

(e) If foreign born, how long in U. S. A? ---- years

3 (a) FULL NAME

Charles William Harvilicz jr.

3 (b) If veteran, name war

00----

3 (c) Social Security Account

No. ---

4. Sex

male

5. Color or race

wh

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-43

8. AGE: Years Months Days If less than one day

--

--

18

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation ----

11. Industry or business ----

12. Name Charles W. Harvilicz sr.

13. Birthplace Pennsylvania

14. Maiden Name Addie Koontz

15. Birthplace Baltimore Md.

16 (a) Informant Elizabeth Harvilicz

(b) Address 510 Calander St

17 (a) Burial (b) Date thereof Sept 9 / 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Annapolis rd Glen Burnie

18 (a) Funeral director Ambrose Inc

(b) Address 414 N Franklin rd

19 (a) SEP 8 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1943 at 8: A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-43 to 9-7-43

and that I last saw him alive on 9-7-43

Immediate cause of death paralytic

ileus

Due to diarrhea and enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations ----

Of autopsy ----

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ----

(b) Date of occurrence ----

(c) Where did injury occur? ----

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 876 Washington Blvd.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07977

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3904 Greenway

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 3904 GREENWAY.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY E. BLAKE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

FEM.

5. Color or race

White6 (a) Single, married, widowed, or
divorced.SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

MAY 14 1889

8. AGE:

Years

Months

Days

If less than one day

84324

hr.

min.

9. Birthplace

BALTIMORE MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

GEORGE A BLAKE

13. Birthplace

IRELAND

MOTHER

14. Maiden Name

HARIET A GRIGGS

15. Birthplace

BALTIMORE MD

16 (a) Informant

MARIA R BLAKE

(b) Address

3904 GREENWAY17 (a) BURIAL

(b) Date thereof

9-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

CATHEDRAL

Location

BALTO MD

18 (a) Funeral director

Bernard C. Harte

(b) Address

21 E West St

19 (a) (b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 7/43 9:35 P21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 4 1943 to Sept 7 1943
and that I last saw h er alive on Sept 7 1943.

Immediate cause of death

Acute PharyngitisDue to MyocarditisDue to advanced arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Francis L. BagliAddress 6077 Hayford RdDate signed 9/8/43

Duration

11 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.SEP 8 - 1943
Wm. Williams M.D.

G 07978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07978

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 821 N. Arlington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 15th

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Cal

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-2-1894

8. AGE:

Years

Months

Days

If less than one day

49

2

3

hr.

min.

9. Birthplace

Maryland

(town, county, and state)

10. Usual Occupation

House work

11. Industry or business

FATHER

12. Name

William White

13. Birthplace

Md

MOTHER

14. Maiden Name

Jennie Marlar

15. Birthplace

Md

16 (a) Informant

Mrs Grace Barber

(b) Address

782 W. Mulberry St

17 (a)

Burial

(b) Date thereof

9-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Arbutus Memorial Park

Location

Arbutus Md

18 (a) Funeral director

William A. Jackson

(b) Address

416 Perryman Ave

19 (a)

Huntington Williams, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

821 N. Arlington Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 5

19

9:00

M

21. I certify that death occurred on the date above stated that I attend-
ed deceased from

and that I last saw him alive on

Immediate cause of death

Cerebral hemorrhage

Duration

24 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

SEP 8 1943

G 07979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07979
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 716 Ensor St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 716 Ensor St
(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Albert Williams

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Male

5. Color or race

Colored6 (a) Single, married, widowed, or
divorcedWidowed

6 (b) Name of husband or wife

Unknown

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 9, 18878. AGE: Years Months Days If less than one day
65 6 11 2 22 hr. 18 min.9. Birthplace Wm. Howard
(Town, county, and state)10. Usual Occupation Culley

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant Laura Jane Gandy(b) Address 716 Ensor St17 (a) Burial (b) Date thereof 9-9-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or place of interment Wm. Howard
Location Baltimore Md.18 (a) Funeral director William A. Jackson(b) Address 911 H. St. Baltimore, Md.19 (a) SEP 8 - 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1943, at 5:00 PM21. I certify that death occurred on the date above stated; that I attended
deceased from 8-20 1942 to 9-7 1943
and that I last saw him alive on 9-4 1943

Immediate cause of death

Arteriosclerosis

Due to

apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward Fisher22 monument Date signed 9-7-43

Duration

17 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 07980
94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Laurens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvanus
3 (b) If veteran, name war 3 (c) Social Security Account No.
4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1885
8. AGE: Years 58 Months Days If less than one day hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name Cottman
13. Birthplace Va.
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant Francis Cottman
(b) Address 1613 Laurens St
17 (a) Burial (b) Date thereof 9/16/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location Catholics Kelly Field
18 (a) Funeral director Chas. A. Alexander
(b) Address 927 N. Mount St

19 (a) SEP day register Washington Williams
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1943, at 8 ³⁵ AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary
occlusion
Infarction of myocardium
Due to
Other Conditions Catarrhal gastritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature Robert Lee Fustum M.D.
Date signed Sept 7 1943 Medical Examiner.

G 07981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07981

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1619 Sarabane St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1619 Sarabane St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

VIRGINIA LEE WATERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

col

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 19228. AGE: Years 21 Months 3 Days 13
If less than one day hr. min.9. Birthplace Balto Md.
(Town, county, and state)10. Usual Occupation Domestic

11. Industry or business

12. Name Harvey Waters13. Birthplace Balto. Md.14. Maiden Name Lillie Johnson15. Birthplace Calvert Co. Md.16 (a) Informant Francis Smith(b) Address 1618 Presbury St.17 (a) Burial (b) Date thereof Sept. 8, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Western Star. Cem

Location

18 (a) Funeral director Mr. Kate R. Williams(b) Address 322 N. Schroeder St.Huntington Williams, M.D.19 (a) SEP 8 1943 (b) Date of death

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1943 at 12:10 PM21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Intercurrent pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. W. Galloway M.D.Date signed Sept. 4, 1943

Source age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07982

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mass (b) County(c) City or town Springfield
(If outside city or town limits, write RURAL and give town)(d) Street No. 162 W. Alvord St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

DOROTHY C. BERRY

3 (b) If veteran, name war
**3 (c) Social Security Account
No. **

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife John W. Berry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/1907

8. AGE:

Years

Months

Days

If less than one day

36

10

0

hr.

min.

9. Birthplace Penna

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Charles M. Clader13. Birthplace Penna14. Maiden Name Aquilla Marsh15. Birthplace Penna.16 (a) Informant Mr. John W. Berry(b) Address 5112 Windsor Mill Rd.17 (a) Removal (b) Date thereof 9/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Hill Crest Cem.Location Springfield, Mass.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19 (a) SEP 8 1943 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 19 43 at 8⁴⁵ P. M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/4 19 43 to 9/6 19 43,
and that I last saw h. an alive on 9/6 19 43.Immediate cause of death Pulmonary
Edema and Bronchopneumonia
and UremiaDue to Hypertension C.V. Dis.Due to Chr. Glom. NephritisOther Conditions Pneumothorax, Pleural
Effusion, Acute
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Chr. Nephritis, Pneum. pleb. Chr.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Raymond B. HurlerAddress Sinai Hosp. Date signed 9/7

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 07983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07983

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND County BALTO.(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 1826 BELT
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial(b) Date thereof 9/9/43

(c) Cemetery or crematory

Location Frederick Ave18 (a) Funeral director William M. March(b) Address 215 Light St

19 (a)

SEP 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/43 at 6:51 M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/25 1943 and that I last saw her alive on 9/7 1943.

Immediate cause of death

Bronco-pneumonia.Due to Acute gastro-enteritis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature Therod J. Maynard M.D.Address So. Baltimore AveDate signed 9/7/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

7984

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07984
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

15 16 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Daniel Martin

13. Birthplace Fairfield, Md.

14. Maiden Name Ruby Crumblin

15. Birthplace Fairfield, Md.

16 (a) Informant Daniel Martin

(b) Address 217 Montford Ave

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 7 1943

18 (a) Funeral director Commissioner of Health

19 SEP 7 - 1943
(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 217 Montford Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1943, at 8:42 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 18 1943, to Sept 4 1943, and that I last saw him alive on Sept 4, 1943.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address Provident Hospital Date signed 7-7-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 131B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 412 N. Caroline St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Lillie Mae Driver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Jeremiah Driver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 2, 1945

8. AGE:

Years

Months

Days

If less than one day

74

4

3

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
MOTHER

12. Name James Barnes

13. Birthplace Md.

14. Maiden Name Louise Johnson

15. Birthplace Md.

16 (a) Informant James Driver

(b) Address 412 N. Caroline St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/8/45

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave.

19 (a) (Date rec'd by registrar)

(b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 412 N. Caroline St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 5 1945, at 5 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 30 1945 to Sept 5 1945

and that I last saw her live on Sept 5 1945

Immediate cause of death

Julius Rosenberg

Due to Ch. myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm. d. Perry

M. D.

Address

1420 E. Chesa

Date signed

Sept 7

SEP 8 - 1945

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07986

BALTIMORE CITY HEALTH DEPARTMENT

G 07986

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.*

(b) County

Baltimore

(c) City or town

Baltimore T. Howard

(If outside city or town limits, write RURAL and give town)

(d) Street No.

6 Shady Side Lane

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Isley Mae Pollack

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or

divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-10-42

8. AGE: Years

Months

Days

If less than one day

*1**1**28*

hr.

min.

9. Birthplace *md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Andrew Pollack

13. Birthplace

Pa.

MOTHER

14. Maiden Name

Mary Morris

15. Birthplace

md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 11/1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

London Park

Location

Baltimore

18 (a) Funeral director

Ellen Smith, Treasurer

(b) Address

3911 Liberty Heights Ave

19 (a)

8-1943

(b)

Thurston Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 7*19*43* at *7 P.* M.21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 6* 19*43* to *Sept. 7* 19*43*and that I last saw her alive on *Sept. 7* 19*43*.

Immediate cause of death

myocardial infarction

Due to

*? Sulfonamide
? diphtheria*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

C. Randolph

Address

Johns Hopkins Hosp

Date signed

9/7/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN BLOCK LETTERS. Physicians: please write the causes of death clearly and legibly. Incorrect age is especially important.

SEP 8-1943

07987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 07987

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 677 Washington Blvd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 677 Washington Blvd

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Josephine Miceli

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband ~~late~~ late Paul Miceli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 1875

8. AGE: Years Months Days If less than one day

68

4

hr.

min.

9. Birthplace Cefalu Italy

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

12. Name Joseph Citrano

13. Birthplace Italy

14. Maiden Name Rose Marsiglia

15. Birthplace Italy

16 (a) Informant Joseph Miceli (Son)

(b) Address 859 Hillman Ct.

17 (a) Burial (b) Date thereof Sept. 9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Morley St.

19 SEP 2 - 1943 (b) *Frank Della Noce* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1943 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1943 to 9-6 1943.

and that I last saw her alive on 9-6 1943

Immediate cause of death

Acute Coronary Disease

Due to Hypertension

Due to Arteriosclerosis

Duration

1 day

10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Joseph R. Lancaster*

Address 677 Washington Blvd. 9/7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07988

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Ellie ~~Ellie~~ May Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Evan Hardy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

P 1912

8. AGE:

31

Months

Days

If less than one day

hr. min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

James Kennedy

13. Birthplace

Va.

14. Maiden Name

Lucy Mae Colvin

15. Birthplace

Va

16 (a) Informant

John Moser

(b) Address

Spartan Point Md.

17 (a)

Burial

(b) Date thereof Sept-9-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Sacred Heart Church

Location

German Hill Rd

18 (a) Funeral director

John G. Connolly

(b) Address

418 Eastern Ave.

19 (a)

SEP 9 1943

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

6908 German Hill Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 6

1943, at 3 05 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept 5 1943 10 25 P.M.

(b) Where did injury occur Eastern Ave & North Point Rd

(c) Did injury occur at home, on farm, industrial place, in public

place? Road While at work? No

(d) Means of injury Auto collision

23. Signature

Robert L. Grattan M.D.

Date signed

Sept. 7 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07989
JL - 81175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07989

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rose Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F 5. Color or race C 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1919

8. AGE: Years 24 Months 0 Days 24 23 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Richard Washington

13. Birthplace Va.

14. Maiden Name Indiana Carter

15. Birthplace Va.

16 (a) Informant B. C. H Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/9/1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co. Md.

18 (a) Funeral director Mayner Sanders

(b) Address 1412 E. Preston St.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1943 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/6 1943 and that I last saw her alive on 9/5 1943.

Immediate cause of death

Pulmonary TBC

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sengman

Address B C H Date signed 9/6

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 9 1943

VB 150

Registrar

07990

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 07990

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bronchus Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *8-0-4*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1406 Argyle Ave.*

(If give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Annie Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years *64* Months Days If less than one day hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL SEP 8 1943*

18 (a) Funeral director

(b) Address

19 (a) *SEP 8 - 1943*

(Date rec'd by registrar)

Commissioner of Health
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-2-1943* at *2:45 PM*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *her* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arterio-chorio-lobes - vascular

Due to

dissection

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Homer J. Mulleis* M.D.

Medical Examiner.

Date signed *9-2-43*

10846

9991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07991
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

President Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1321 Lombard Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Nichols

Twin #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female Colored

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
2 hr. 4 min.9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Clarence Nichols

13. Birthplace Baltimore Md

14. Maiden Name Bessie Virginia Moore

15. Birthplace Bupet County N.C.

16 (a) Informant Mrs Clarence Nichols

(b) Address 1321 Lombard St

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 8 1943

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 8 - 1943 (b) Huntington Williams, M.D.
Date of death Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1943 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23-1943 to 8-23-1943, and that I last saw him alive on 8-23-1943.

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature G. J. Brumfield

Address Fox Chase Hospital Date signed 9-5-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 07992**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Prudent Hop

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.*

(b) County

(c) City or town

Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.

1321 Lombard St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Nichols

Twin #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 24-1943

8. AGE:

Years

Months

Days

If less than one day

20 hr.

15 min.

9. Birthplace

Baltimore Ind

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Clarence Nichols

13. Birthplace

Baltimore Ind

14. Maiden Name

Arnetta Moore

15. Birthplace

Bufile County N.C.

16 (a) Informant

Mrs. Agnes Nichols

(b) Address

1321 Lombard St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL SEP 8 1943*

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 8 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 24 1943 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 23 1943* to *Aug 24 1943* and that I last saw him alive on *8-24-1943*.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. J. ...

Address

Prudent Hop

M. D.

Date signed *9-5-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 07993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07993

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 618 E Pratt St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WALTER B AYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 21, 1899

8. AGE:

Years

Months

Days

If less than one day

45

45

11

14

hr.

min.

9. Birthplace

Charlotte, N.C.

(Town, county, and state)

10. Usual Occupation

Meat Cutter

11. Industry or business

FATHER
MOTHER

12. Name

Ashworth, Cyra

13. Birthplace

South Carolina

14. Maiden Name

Myra J. Furr

15. Birthplace

South Carolina

16 (a) Informant

Carl B. Wells (Undertaker)

(b) Address

Monroe, N.C.

17 (a)

Removal

(b) Date thereof

9/9/43

(month) (day) (year)

(c) Cemetery or crematory

Monroe

Location

N.C.

18 (a) Funeral director

William Cook Inc

SEP 9 - 1943

St. Paul St

19 (a)

(Date rec'd by registrar)

Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5, 1943, at 7 P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hemorrhage, internal

Due to

Rupture of bladder

Other Conditions

Cerebral hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-5-43, 4: P. M.

(b) Where did injury occur? Home address

(c) Did injury occur at home, on farm, industrial place, in public place? Inside While at work?

(d) Means of injury fell down steps of hotel

23. Signature N. Z. Wallenmeyer M.D.

Medical Examiner.

Date signed 9-5-43

G 07994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07994
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4940 Eastern Ave.
- (c) Hospital or institution:
Baltimore City Hospitals
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 862 days
- (e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County _____
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 723 W. Lexington St.
(If rural give location)
- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

William Chance65427

3 (b) If veteran, name war

no

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Pearl A. Chance

6 (c) If alive, give age

44 years

7. Birth date of deceased (mo., day, yr.)

Dec. 2, 1890

8. AGE:

Years

52

Months

8

Days

29

If less than one day

hr.

min.

9. Birthplace

Md.(Town, county, and state)
presman

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

William Chance

13. Birthplace

Md.

14. Maiden Name

Emma Smith

15. Birthplace

Md.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Sept 9, 1943
(month) (day) (year)

(c) Cemetery or crematory

Western

Location

City

18 (a) Funeral director

Sam. Mrs. J. W. Zupfel & Son

(b) Address

801 W. Lexington St.SEP 9 - 1943
(Date rec'd by Registrar)Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 11943at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28, 1941 to Sept. 1, 1943, and that I last saw him alive on Sept. 1, 1943.

Immediate cause of death

Pulmonary tuberculosis

Duration

5 yrs?

Due to

Due to

Other Conditions

Mixed empyemaBroncho-pulmonary fistula

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Suggman

Address

ACH

Date signed

9/9

07995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G-02995

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 436 S Cornwall St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 436 S Cornwall St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harvey W. Reinert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Ella Reinert

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1883

8. AGE: Years 59 Months 11 Days 7 1/2 hr. min.

9. Birthplace Guthrie Pa
(Town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business Bethlehem Steel

12. Name Wm Reinert

13. Birthplace Pa

14. Maiden Name Henrietta Smith

15. Birthplace Pa

16 (a) Informant Ella Reinert

(b) Address 436 S Cornwall St

17 (a) Removal (b) Date thereof Sept 24
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Glenmont Cem.
Location Northampton Pa

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004-8 Orleans St

19 (a) SEP 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1943, 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1943, to Sept 7, 1943, and that I last saw him alive on Sept 7, 1943.

Immediate cause of death

Carcinoma of stomach 6 months

Due to

Other Conditions

(Include pregnancies within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. J. Parr

Address 516 Baltimore St Date signed 9-9-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

07996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07996
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(d) Street No. 50 W. West St. (If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (If rural give location)

(Yes or No)
If yes, name country

3 (a) FULL NAME

Milford Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

Negro

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

37

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 9 - 1943

(Date rec'd by Registrar)

(b) Address for William M. J.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-1943, at 2:22 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arterial aneurysm of neck,
involving carotid artery &
other vessels

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-5-43 at 2 A M

(b) Where did injury occur? Street in front of 50 W. West St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Sharp instrument

23. Signature Howard J. Malden M.D.

Date signed 9-5-43

Medical Examiner.

07997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 07997
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) Since 1921

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town 1014 Bennett Place, Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1014 Bennett Place, Baltimore, Md.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

HERNDON WHITE

3 (b) If veteran, name war
Sp. American3 (c) Social Security Account
No.4. Sex
Male5. Color or race
Col.6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Katrine Nelson

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 20, 1876

8. AGE: Years Months Days If less than one day
67 3 19 hr. min.

9. Birthplace Summit, Va.

(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

12. Name Richard White

13. Birthplace Va.

14. Maiden Name Elizabeth ?

15. Birthplace Va.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9-11-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Co

(b) Address 108 W. Montgomery St

SEP 9 - 1943

Date of death

(b) Registrar
H. H. Williams, M.D.

VB 154

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 8, 1943, at 4:10 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 21, 1943, to Sept. 8, 1943,
and that I last saw him alive on Sept. 8, 1943.

Immediate cause of death

Hodgkin's Disease

Duration

Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 9/8/43

Va-13590

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 07998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07998

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3407 Elgin Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

JOHN S. KLINGSTINE

3 (b) If veteran, name war

3 (c) Social Security Account
No. --

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widower

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1859

8. AGE: Years Months Days If less than one day

83

8

9

hr.

min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation retired Conf.

11. Industry or business Own business

12. Name Joseph Klingstine

13. Birthplace Germany

14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs. Andrew L. Kimball

(b) Address 3407 Elgin Ave.

17 (a) Burial (b) Date thereof 9/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory - New Cathedral

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address North & Pa., Balto., Md.

SEP 9 - 1943

(Date rec'd by registrar)

Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1943, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1939 to 9/5 1943, and that I last saw him alive on 9/5 1943.

Immediate cause of death

myocardial insufficiency
+ Pulmonary edema

Due to

arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert A. Reiter

Address 3407 W. Underwood Ave. Date signed 9/9/43

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 07999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 07999

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4517 Pimlico Road

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or

married

6 (b) Name of husband or wife

Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE:

67

Years

Months

Days

If less than one day

9. Birthplace

Leth

(Town, county, and state)

10. Usual Occupation

Retired Merchant

11. Industry or business

12. Name

Lease Brooks

13. Birthplace

Leth

14. Maiden Name

Lena

15. Birthplace

Leth

16 (a) Informant

Wife

(b) Address

same

17 (a)

Burial

(b) Date thereof

Sept. 10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Funeral HomeLocation Balto & Conklin St.

18 (a) Funeral director

Jack J. J. J.

(b) Address

1438 E. Balto St.

19 (a)

(b)

SEP 9 - 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

4517 Pimlico Road

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 8 1943

21. I certify that death occurred on the date above stated; that I attended

deceased from April 16 1943 to Sept 8 1943and that I last saw him alive on Sept 8 1943

Immediate cause of death

Coronary thrombosis

Duration

5 hrs

Due to

arteriosclerosis and chronic myocarditis4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

no

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph H. Zierler

Address

238 E. Balto St.Date signed 9/8/43

M.D.

G 08000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08000

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 312

(c) Hospital or institution: Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Baltimore

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 313 (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Coastline Baloris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 5 - 1942

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(burial, cremation, or removal)

(b) Date thereof

9-9-43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1943 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1943 to 9/8 1943 and that I last saw her alive on 9/8 1943.

Immediate cause of death

Dehydration

Due to

Infections diarrhea

Other Conditions

Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Dehydration Malnutrition

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

E. Symonds Rogers

Address

Bon Secours Hosp.

M.D.

Date signed 9/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08001

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2341 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ALBERT H BROWN

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-09-1619

4. Sex

m

5. Color or race

bl

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Maud Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1885

8. AGE:

Years

Months

Days

If less than one day

58

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Henry A Brown

13. Birthplace

Baltimore Md

14. Maiden Name

Laura Clements

15. Birthplace

Baltimore Md

16 (a) Informant

Maud Brown

(b) Address

2341 Madison Ave

17 (a)

Burial

(b) Date thereof

Sept 11-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Zion Cemetery

Location

18 (a) Funeral director

Jr Brooks

(b) Address

1463 N. Carey St.

19 (a)

SEP 9 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1943 at 5:20 PM

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature W. J. Wallenmeyer M.D.

Medical Examiner.

Date signed 7-8-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08002

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08002

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08003
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

VS 136

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/7/1943 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1943 to Sept 7 1943.

and that I last saw her alive on Sept 7 1943.

Immediate cause of death

Peritonitis

Duration

4 hours

Due to

Perforation of sigmoid colon

4 hours

Due to

Other Conditions

(Include pregnancy within months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **2**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edward Gosnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-8-75

8. AGE:

Years

Months

Days

If less than one day

68**8****-**

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name **Edward Gosnell**13. Birthplace **MD**14. Maiden Name **Ida Lee**15. Birthplace **MD**

16 (a) Informant

Records
JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) **BURIAL**

(b) Date thereof

9/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London PARKLocation **BALTO. MD**

18 (a) Funeral director

HARRY H. WITZKE

(b) Address

4101 Edmondson AVE19 **SEP 9 - 1943****Therese M. Williams**

Registrar

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08004

Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **5233 Cuthbert AVE**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 8 1943** at **2401 M**21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 4 1943** to **Sept 8 1943**, and that I last saw him alive on **Sept 8 1943**.

Immediate cause of death

Carcinoma of the left lungDue to **metastases to right**Due to **lung**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Robert Day**Address **Johns Hopkins Hosp.** Date signed **9/10/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08005

AB-57218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08005

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 490 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1r. 284 days(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1247 Edythe St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married-Separated6 (b) Name of husband or wife Bertha-Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1884

8. AGE: Years

Months

Days

If less than one day

59516

hr.

min.

9. Birthplace S.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John Smith13. Birthplace S.C.14. Maiden Name Sarah Fullord15. Birthplace S.C.16 (a) Informant Baltimore City Hospitals(b) Address Records17 (a) Burial (b) Date thereof 9/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy Wilson(b) Address 1400 Belmont Ave.SEP 9-1943 (c) Huntington, N.Y.

(State rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1943 at 7:15 P21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/43 1943 to 9/6 1943.and that I last saw him alive on 7/6 1943.Immediate cause of death Coronary
vascular accident

Disease

3 M.Due to H. C. V. D.

Due to

Other Conditions Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury E. L. Sengman23. Signature E. L. SengmanAddress 10 CH Date signed 9/8

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08006

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3 Midvale Road
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
3 Midvale Road
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Helen Louise Legge

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Female5. Color or race
white6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife John E. Legge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/1887

8. AGE: Years 56 Months 7 Days 2
If less than one day
hr. min.

9. Birthplace Ohio.

(Town, county, and state)

10. Usual Occupation home duties

11. Industry or business

12. Name Dr. Jos. C. Gordon

13. Birthplace Pa.

14. Maiden Name Lucinda Corey

15. Birthplace Vermont

16 (a) Informant Dr. John E. Legge

(b) Address 3 Midvale Road

17 (a) Burial (b) Date thereof 9/9/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemy.

Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 SEP 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943, to Sept 7, 1943, and that I last saw him alive on Sept 6, 1943.

Immediate cause of death

Carcinomatosis
Carcinoma of
Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

2 yrs

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Tonella

Address 817 Park Ave.

Date signed 9/10/43

08007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08007

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 9 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 640 S. Macan St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1943, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8-28 1943 to 8-28 1943.

and that I last saw him alive on 9-6 1943

Immediate cause of death

Cerebral Thrombosis

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Alfred J. Harrison

Address St. Agnes Hosp Date signed 9-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08008
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. ?

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1869

8. AGE: Years Months Days If less than one day
74 3 2 8 7 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Catherine S. Suit

(b) Address 3220 Warder St., N. W.,
Washington, D. C.17 (a) Burial (b) Date thereof 9/10/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Calvary
Location Upper Marlboro, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (c) SEP 9 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4304 Maine Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

Josephine (Josie) Woods

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1943 11:50 PM

21. I certify that death occurred on the date above stated; that I attended
deceased from Aug 28 1943 to Sept 7 1943
and that I last saw her alive on Sept 7 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address Date signed

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Physician's signature and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08009
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2927 Monument St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2927 Monument St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

GEORGE H. WESTERMEYER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or
divorced.

widower

6 (b) Name of husband or wife Irene Westermeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1892

8. AGE: Years Months Days If less than one day

51

1

1

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Peerless Laundry

FATHER

12. Name Rudolph Westermeyer

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Susanna Benner

15. Birthplace Baltimore, Md.

16 (a) Informant Louis Westermeyer (Son)

(b) Address 2927 Monument St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept. 11, 1943
(month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location

Maryland

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison St.

19 SEP 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1943 at 9:30 PM

21. I certify that I took charge of the remains described above, held an

Inquiry, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature W. J. Wallenweber M.D.

Date signed 9-8-43

G 08010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08010

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Sinai Hospital*

(c) Hospital or institution:

Monument & Rutland(d) Length of stay in hospital or inst. (yrs., mos., or days) *7*(e) Length of stay in Baltimore (yrs., mos., or days) *6 weeks*

2. USUAL RESIDENCE OF DECEASED:

(a) *New York*(c) City or town *New York*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Hotel Empire*

(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

none

(c) Social Security Account

No. *123-16-5897*

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

*Widower*6 (b) Name of husband or wife *Martha Huchberger*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 4, 1865*

8. AGE: Years Months Days If less than one day

77 10 4 hr. min.9. Birthplace *Germany*

(Town, county, and state)

10. Usual Occupation *Radio Business*

11. Industry or business

12. Name *Abraham Huchberger*13. Birthplace *Germany*14. Maiden Name *Sarah Wolfshiemer*15. Birthplace *Germany*16 (a) Informant *W. Africa Huchberger*(b) Address *1060 Park Ave. - New York**Removal & Burial* Date thereof *9/19/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Beth - El*Location *Queens Co. Long Island, N.Y.*18 (a) Funeral director *David Schneiderman*(b) Address *1902 Eastview Place*19 (a) *SEP 9 - 1943*(b) *Huntington, N.Y.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/8* 19*43*, at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *8/16* 19*43*, to *9/8* 19*43*I last saw him alive on *9/5* 19*43*Immediate cause of death *Trauma**Pneumonia & Uremia*Due to *Ch. Isov. Infection*Due to *Generalized Arteriosclerosis*Other Conditions *Parkinsonism**Intestinal Obstruction*

(Include pregnancy within 3 months of death)

Date of operation *Aug. 18/43*Major findings of operation: *Anger**Prostate Hypertrophy*of autopsy: *Pneum. P.H. Uremia, Infection*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Raymond B. Healy*Address *Sinai Hosp.* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-83722 08011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08011
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 320 S. Hanover St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Ella Hanlon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife. Timothy (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1882

8. AGE: Years Months Days If less than one day

61

3

25 day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation D.P.W.

11. Industry or business

12. Name Griesberry McAllister

13. Birthplace Md.

14. Maiden Name Eliza Baker

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 9/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1943 at 6:10 P

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1943 to 9/7 1943.

and that I last saw her alive on 9/7 1943.

Immediate cause of death. Pneumonia, advanced

embolism of liver

Due to alcoholism

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Subacute degenerative

of autopsy: Advanced embolism of liver

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Seigman

Address B C H

Date signed 9/8

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

SEP 9 - 1943

G 08012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08012
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Med. General Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *20A*(e) Length of stay in Baltimore (yrs., mos., or days) *1 year*

3 (a) FULL NAME

3 (b) If veteran, name war

*NO*3 (c) Social Security Account
No. *087.05:4316*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ellen Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 24, 1888

8. AGE:

Years

Months

Days

If less than one day

*55**7**14**hr*

min.

9. Birthplace

Brooklyn N.Y.

(Town, county, and state)

10. Usual Occupation

Superintendent

11. Industry or business

*St. Louis*FATHER
MOTHER

12. Name

John J. Crawford

13. Birthplace

St. Louis

14. Maiden Name

Rebecca Noonan

15. Birthplace

St. Louis

16 (a) Informant

Ellen M. Crawford

(b) Address

3325 W. Thacker Avenue

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

9/9/43

(c) Cemetery or crematory

St. James

Location

St. James, Brooklyn N.Y.

18 (a) Funeral director

Thompson & Co.

(b) Address

1214 St. Paul St.

19 (a)

(Date rec'd by registrar)

SEP 9 - 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3225 W. Thacker Avenue

(If rural give location)

(e) Citizen of foreign country?

Yes

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 8*1943, at *4* P.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH *Cornary occlusion*Due to *Angina pectoris*

Other Conditions

Gastric ulcer

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Robert L. Grotz* M.D.Date signed *Sept. 9 1943*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information collected is especially important. Physicians: please write the causes of death clearly and legibly.

08013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08013
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 339 S. Ann St.

(If rural give location)

(e) Citizen of foreign country? NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

MARIE FRANK GOFF

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Walter Frank Goff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1882

8. AGE:

Years

Months

Days

If less than one day

60

9

29

28

hr.

min.

9. Birthplace Green County, Penna.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Penna

MOTHER

14. Maiden Name Unknown

15. Birthplace Penna

16 (a) Informant Mr. Louis Goff

(b) Address 1820 E. Lombard St.

17 (a) Burial

(b) Date thereof 9/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oaklawn Cemetery

Location Baltimore County, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1349 E. North Ave.

9-1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/8

1943, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1943, to 9/8 1943, and that I last saw her alive on 9/8 1943.

Immediate cause of death

Pulmonary edema

Due to Left ventricular failure

Due to Hypertension

Other Conditions Atherosclerosis + Pneumonia of left lung?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Donald H. Hinkle

Address

339 S. Ann St.

Date signed 9/8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. **G 08014**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Nursing Home

(c) Hospital or institution:

2101 Cold Spring Lane

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 27-15(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. Nursing Home
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Arthur Bowles

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE:

62

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 7 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19 SEP 7 - 1943 Montgomery Williams, M.D.
(Date for filing)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1943 at 6:15 P.M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature

Hugh B. McNally, M.D.
Medical Examiner.

Date signed

9/1/43.

8015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08015
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 84 da.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Wilson Butcher

81972

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. sep.

6 (b) Name of husband or wife Audrey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1909

8. AGE:

Years

Months

Days

If less than one day

? 34

hr.

min.

9. Birthplace

Washington

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

?

13. Birthplace

?

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant Hospital records

(b) Address 4940 Eastern Ave

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 9 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 9 1943 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1943 at 9:00A M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1/43 June 11 1943 to Sept. 3 1943
and that I last saw him alive on Sept. 3 1943

Immediate cause of death

Pulmonary tuberculosis

Duration

4 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. L. Sargman

Address B C H

Date signed 9/9

PLEASE WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS: please write the causes of death clearly and legibly.
correct age is especially important.

VS 100

0349

08016

AB-83539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08016

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4940 Eastern Ave.
- (c) Hospital or institution:
Baltimore City Hospitals
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
- (e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1047 Aisquith St.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Linwood Cheatham

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-09-1666

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married-Separated

6 (b) Name of husband or wife

?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 30-1908

8. AGE:

Years

Months

Days

If less than one day

34

10

9

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name Charlie Cheatham

13. Birthplace Va.

14. Maiden Name Mary Cheatham

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

16 (b) Address Records

17 (a) Burial (b) Date thereof 9/15/43

17 (c) Cemetery or crematory Mt Calvary

17 (d) Location

18 (a) Funeral director Des. H. Kelson

18 (b) Address 1303 President St.

18 (c) Date rec'd by Registrar

18 (d) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/1

19 43 at 9:08 A

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1943 to 9/1 1943 and that I last saw him alive on 9/1 1943.

Immediate cause of death

Cerebro-vascular accident

Duration

12 hr.

Due to

Malignant hypertension

2 yr.

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
- (e) Means of injury

23. Signature E. L. Seymour

Address B C H

Date signed 9/9

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08017
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1727 E. 75 St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn

(b) County

(c) City or town Mc Connellsburg

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Carrollus Watson Prosser

3 (b) If veteran, name war

3 (c) Social Security Account
No. 191-07-6528

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

Marguerite Prosser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1876

8. AGE:

Years 66

Months 11

Days 11

If less than one day

hr.

min.

9. Birthplace

New Freedom Pa

(Town, county, and state)

10. Usual Occupation

Accountant

11. Industry or business

H. B. McLean

FATHER

12. Name

William Prosser

13. Birthplace

New Freedom Pa

MOTHER

14. Maiden Name

Kathryn Earhart

15. Birthplace

New Freedom Pa

16 (a) Informant

Marguerite Prosser

(b) Address

1727 E 75 St

17 (a)

Burial

(b) Date thereof

9/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ebenezer

Location

Chase Md.

18 (a) Funeral director

William G. G. S. C.

(b) Address

1217 St Paul St

SEP 10 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 7 1943 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1943 to Sept 7 1943 and that I last saw her alive on Sept 7 1943.

Immediate cause of death

Carcinoma Prostate
and Bladder

Duration

6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. F. Stevens

Address

7878 Harford Rd

Date signed 9/8/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the causes of death clearly and legibly.

08018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G 08018

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3308 Presstman Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Presstman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

PAYNE
CATHERINE MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

widowed

6 (b) Name of husband William Morgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1853

8. AGE: Years Months Days If less than one day

90

3

3

2

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name

John J. Payne

13. Birthplace

Jefferson G. Va

14. Maiden Name

Catherine Denner

15. Birthplace

Va

16 (a) Informant

John Payne Blair

(b) Address

2505 Guilford Ave

17 (a) Burial (b) Date thereof 9 10 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Balto. Md.

18 (a) Funeral director

Wm. Cook, Inc

(b) Address

1217 St. Paul St

19 (a) SEP 10 1943
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

7:15 P.

20. DATE OF DEATH September 7, 1943 at M

21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Wallenmacher M.D.

Date signed

G 08019
440673BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937G 08019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Jesse Bayne

3 (b) If veteran, name war

3 (c) Social Security Account
No. 228-16-6036

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Delilah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3-3-97

8. AGE:

Years
46Months
6Days
6

If less than one day

hr.

min.

9. Birthplace

VA

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

John Bayne

13. Birthplace

VA

14. Maiden Name

MARTHA

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Removal

(b) Date thereof

Sept 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Keysville, Virginia

18 (a) Funeral director

Mrs. Robert A. Elliott & Daughter

(b) Address

112 971 Caroline St.

19 SEP 10 1943

(b) Huntington, Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1017 N. Gay

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 9 1943, 231 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1943 to Sept 9 1943, and that I last saw him alive on Sept 9 1943.

Immediate cause of death

Cerebral Haemorrhage

Duration

6 days

Due to

Hypertensive Cordis -
-Vascular Disease.

12 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

TBSchwarz

M. D.

Address

Date signed

G 08020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08020

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 2803 Garrison Blvd.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2705 Allendale Rd.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

LILLIE MARGARET WEBSTER

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ira S. Webster
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1981

8. AGE: Years 62 Months 2 Days 5 If less than one day hr. min.

9. Birthplace Deals Island, Md.
 (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Wilbur J. Thomas

13. Birthplace Deals Island, Md.

14. Maiden Name Mary F. Anderson

15. Birthplace Deals Island, Md.

16 (a) Informant Mr. Ira S. Webster

16 (b) Address 2705 Allendale Rd.

17 (a) Burial (b) Date thereof 9/10/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.
 Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

18 (b) Address Balto., Md.

19 (a) SEP 10 1943

19 (b) Handwritten signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1943, at 6:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1943 to Sept 7, 1943, and that I last saw her alive on Sept 7, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. H. Campbell M. D.

Address 1644 Hanover St. Date signed

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08021

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 08021
61 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 226 Cold Spring La.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FRANK CLIFFORD GILL

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. 215-18-7616

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Virginia E. Gill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1890

8. AGE:

Years

Months

Days

If less than one day

53

4

27

hr.

min.

9. Birthplace Newport News, Va.

(Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Bethlehem Ship Bldg. Co.

12. Name Joseph Harry Gill

13. Birthplace Chambersburg, Pa.

14. Maiden Name Amanda M. Eagle

15. Birthplace Yorktown, Va.

16 (a) Informant Mrs. Virginia Seney Gill

(b) Address 226 W. Cold Spring Lane

17 (a) Burial (b) Date thereof 9/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address North & Pa., Balto., Md.

19 (a) Date of registration 10/10/43 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1943, at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to Sept 8, 1943 and that I last saw him alive on Sept 8, 1943.

Immediate cause of death

Cerebral Hemorrhage
Due to Cerebral Arteriosclerosis
& Elongation

Due to

Other Conditions Hypoglycemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel J. Williams, M.D.

Address Tawson, Md. Date signed 9/14/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08022
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME HARRY CLAUDE PREIS

3 (b) If veteran, name war World's War 3 (c) Social Security Account
No. 213 - 03 - 2727

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah Gaphardt
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 9/21/95
8. AGE: Years 47 Months 11 Days 18
If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newspaper work
11. Industry or business _____

FATHER 12. Name Francis Preis
13. Birthplace Germany
MOTHER 14. Maiden Name Elizabeth Kaiser
15. Birthplace Germany

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9/11/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 10 1943 (b)

VB 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17, 1943 to Sept. 9, 1943, and that I last saw him alive on Sept. 9, 1943.

Immediate cause of death
Hypertrophic cirrhosis of the liver

Due to _____
Due to _____

Other Conditions _____
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: _____
of autopsy As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence _____ at M
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(e) Means of injury _____
23. Signature *[Signature]*
Address Baltimore, Md. Date signed 9/16/43

Duration Unknown
PHYSICIAN
Underline the cause to which death should be charged statistically.

Va-13579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 117a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3509 Edgewood Rd.
(c) Hospital or Institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3509 Edgewood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM MARSHALL ROBINSON

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Bessie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1872

8. AGE: Years Months Days If less than one day

71

3 8

28

hr.

min.

9. Birthplace Fulton Co., Pa. (McConnellsburg)
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Standard Oil Co.

FATHER 12. Name John A. Robinson

13. Birthplace Carlisle, Pa.

MOTHER 14. Maiden Name Ann Sophia McNulty

15. Birthplace Chambersburg, Pa.

16 (a) Informant Mrs. Bessie M. Robinson

(b) Address 3509 Edgewood Rd.

17 (a) Burial (b) Date thereof 8/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Presby. Ch. Cem.

Location McConnellsburg, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto., Md.

19 (a) SEP 10 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2, 1943, to Sept. 8, 1943, and that I last saw him alive on Sept. 8, 1943.

Immediate cause of death

Myocarditis
acute dilatation of heart
Due to advanced arterio-sclerosis
Gastric ulcer

Due to

Other Conditions

Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 2220 Garrison St. Date signed 9/9/43

Duration

1 mo.

1 day

1 yr.

2 yrs.

3 yrs.

4 yrs.

5 yrs.

6 yrs.

7 yrs.

8 yrs.

9 yrs.

10 yrs.

11 yrs.

12 yrs.

13 yrs.

14 yrs.

15 yrs.

16 yrs.

17 yrs.

18 yrs.

19 yrs.

20 yrs.

21 yrs.

22 yrs.

23 yrs.

24 yrs.

25 yrs.

26 yrs.

27 yrs.

28 yrs.

29 yrs.

30 yrs.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08025

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **822 N. Carrollton Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **16**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EMMA J. COLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **Colored** 6 (a) Single, married, widowed, or divorced **Widow**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1871**

8. AGE: Years **72** Months Days If less than one day hr. min.

9. Birthplace **Baltimore, Md.**
(Town, county, and state)

10. Usual Occupation **None**

11. Industry or business

FATHER 12. Name **William Dorsey**

13. Birthplace **Md.**

MOTHER 14. Maiden Name **Mary J. ?**

15. Birthplace **Md.**

16 (a) Informant **N. M. Carroll Aged Home**

(b) Address **822 N. Carrollton Ave**

17 (a) **Burial** (b) Date thereof **9-11-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Laurel Cem**
Location **Baltimore, Md.**

18 (a) Funeral director **Mrs Frances A. Hemsley**

(b) Address **578 W. Biddle St.**

19 (a) **SEP 10 1943** (b) Registrar **Thurston Williams**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County

(c) City or town **Baltimore.**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **822 N. Carrollton Ave.**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 8, 1943** at **8:30 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug. 30, 1943** to **Sept 8, 1943**, and that I last saw him alive on **Sept 8, 1943**.

Immediate cause of death

Cerebral Hemorrhage 9 days

Due to **Hypertension**
Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Ralph W. Recklin**

Address **426 N. Gilmor** Date signed **9/10/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G

08026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08026

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *22 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1840 Rutland Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

GEORGE P. LEWIS Jr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. *212-03-7857*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 8 1943, 9 A.M.*

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Anna Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 16/1904

8. AGE:

Years

Months

Days

If less than one day

*39**1**23**22*

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

FATHER
MOTHER

12. Name

Geo. P. Lewis Sr.

13. Birthplace

md.

14. Maiden Name

Mary Gardner

15. Birthplace

md.

16 (a) Informant

Mrs. Anna Lewis

(b) Address

1840 Rutland Ave

17 (a)

Burial

(b) Date thereof

9 11 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Baltimore

18 (a) Funeral director

Philip Henry Long

(b) Address

20 24 Orlean St

19

*SEP 10 1943**Huntington Williams Jr.*

Registrar

21. I certify that I took charge of the remains described above, held an *inspection* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Cornary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *W. J. Wallenweller M.D.*Date signed *9-8-43*

G 08027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08027

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 10 1943

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1943, to Sept. 8, 1943, and that I last saw him alive on Sept. 2, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address 1319 Light St. Date signed 9/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08028

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08028
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 419 McCallum St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) 2/17/43

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 419 McCallum St
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Laura B. Townsend

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or
divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/17/43

8. AGE:

Years

Months

Days

If less than one day

4+

22

hr.

min.

9. Birthplace Norfolk, Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Willis Belk

13. Birthplace Norfolk, Va.

14. Maiden Name Dorothy Townsend

15. Birthplace Norfolk, Va.

16 (a) Informant Dorothy Townsend

(b) Address 419 McCallum St

17 (a) Burial (b) Date thereof 9/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Anne Arundel Co. Md.

18 (a) Funeral director J. L. Lewis

(b) Address 1100 Davis St

19 SEP 10 1943

(Date rec'd by registrar)

H. L. Lewis

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1943 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/26 1943 to 8/28 1943
and that I last saw her alive on 8/28 1943

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

Pneumonia

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. L. Lewis, M.D.

Address 1100 Davis St

Date signed 9/14/43

Duration

2 days

100%

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

The cause of death should be carefully supplied. The cause of death should be written in plain language, and the cause of death should be written in plain language.

08029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08029

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3620 Parkdale Ave.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 13(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Parkdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Carrie E. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account
No. 215-06-0480

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Howard Bowen6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

Jan. 26, 1885

8. AGE: Years

58

Months

Days

If less than one day

hr.

min.

9. Birthplace MD.

(Town, county, and state)

10. Usual Occupation

Speaker Master

11. Industry or business

Latton MillFATHER
MOTHER12. Name Mahlon Pae13. Birthplace MD.14. Maiden Name Ila Ambrose15. Birthplace MD.16 (a) Informant James W. Pae(b) Address 1111 W. 22nd St.17 (a) Burial (b) Date thereof Sept 11, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory WoodlawnLocation Woodlawn MD.18 (a) Funeral director Chas. W. Williams(b) Address 3611 1st St.SEP 10 1943Huntington Williams, M.D.
Registrar

VS 184

Will call in date of 9/10/43

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8, 1943 at 2:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1, 1943 to Sept 8, 1943, and that I last saw her alive on Sept 7, 1943

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edwin J. HarrisonAddress 403 T. Falls Rd. Date signed 9/9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08030
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33rd. & Calvert

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

16 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1405 Union Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Joseph Whitely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 24, 1927

8. AGE:

Years

Months

Days

If less than one day

16

76

13

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Raymond E. Whitely

13. Birthplace

Baltimore, Md.

14. Maiden Name

Helen E. Garrison

15. Birthplace

Baltimore, Md.

16 (a) Informant

Hospital Records.

16 (b) Address

17 (a)

Burial

(b) Date thereof

Sept 10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Moulton Park

Location

Taylor Ave

18 (a) Funeral director

Edmund J. Somoran

(b) Address

3615-17 Chestnut Ave

19 (a)

19

Sept 10 1943

(b)

Huntington Williams, Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 7 1943. at 1:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1943. to Sept 7 1943. and that I last saw him alive on Sept 7 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Cerebral Embolism

Due to

Rheumatic Heart

Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Cerebral Hemorrhage

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John A. Fresh

Address

33rd & Calvert

Date signed 9/7/43

Duration

Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08031 MJ-83644		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 30E		G 08031 Registered No.	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address 4940 Eastern Ave. (c) Hospital or institution: BALTIMORE CITY HOSPITALS (d) Length of stay in hospital or inst. (yrs., mo., or days) 5 days (e) Length of stay in Baltimore (yrs., mo., or days) 1 yr			2. USUAL RESIDENCE OF DECEASED: (a) State Maryland (b) County (c) City or town Baltimore (If outside city or town limits, write RURAL and give town) (d) Street No. 608 S. Robinson St. (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country		
3 (a) FULL NAME George Schroeder			3 (b) If veteran, name war		
3 (c) Social Security Account No.			MEDICAL CERTIFICATION		
4. Sex Male			5. Color or race White		
6 (a) Single, married, widowed, or divorced Widowed			20. DATE OF DEATH 9/9/43 19 at 5:30 AM		
6 (b) Name of husband or wife			21. I certify that death occurred on the date above stated; that I attended deceased from 9/4/43 19 to 9/9 1943, and that I last saw him alive on 9/7 1943.		
6 (c) If alive, give age years			Immediate cause of death Cardiac compensation		
7. Birth date of deceased (mo., day, yr.) Mar 23, 1896			Duration 1 yr		
8. AGE: Years 47 Months 5 Days 16 If less than one day hr. min.			Due to ? Arteriosclerosis		
9. Birthplace Maryland (Town, county, and state)			Due to ? Syphilis heart		
10. Usual Occupation			Other Conditions		
11. Industry or business Stevedor			(Include pregnancy within 3 months of death)		
12. Name George			Date of operation		
13. Birthplace Maryland			Major findings of operations:		
14. Maiden Name Mary Luckart			of autopsy: As above		
15. Birthplace Maryland			22. If death was due to external causes, fill in the following:		
16 (a) Informant BALTIMORE CITY HOSPITALS			(a) Accident, suicide, or homicide		
16 (b) Address (RECORDS)			(b) Date of occurrence at M		
17 (a) Burial (b) Date thereof 10-13-43 (month, day, year)			(c) Where did injury occur? (City or town) (County) (State)		
(c) Cemetery or crematory New National Frederick Rd.			(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?		
18 (a) Funeral director John A. Moran			(e) Means of injury		
19 (a) SEP 10 1943 (b) 000 E. Baltimore St. Registrar			23. Signature Paul Mott		
19 (a) (Date rec'd by registrar)			Address R.C.H.		
19 (b) (Date signed)			Date signed 9/9/43		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 08032

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3702 Chatham Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

William

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3702 Chatham Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 218-01-3236

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Katherine Volke

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1875

8. AGE: Years Months Days If less than one day

68 7 15 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Hardware Merchant

12. Name William Volke

13. Birthplace Germany

14. Maiden Name Christine Bailey

15. Birthplace Germany

16 (a) Informant Katherine Volke

(b) Address 3702 Chatham Road

17 (a) Burial (b) Date thereof Sept 11, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location City

18 (a) Funeral director Mr. Mrs. John R. Trefel, Son

(b) Address 801 W. Fayette St.

19 (a) (b)

(Signature of registrar)

SEP 10 1943

Huntington Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1943 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan. 12, 1940, to Aug. 25, 1943,

and that I last saw him alive on Aug. 25, 1943.

Immediate cause of death Central

hemorrhage

Due to Hypertensive arterio-

sclerotic cardio-vascular

Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. R. Trefel, M.D.

Address 3403 Garrison Blvd Date signed Sept 9

Ede

G 08033

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08033
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1220 E. Monument St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JOHN BROWN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

MALE

5. Color or race

COLORED

6 (a) Single (married, widowed, or divorced)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

1887

8. AGE:

Years

Months

Days

If less than one day

56

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Rebecca Brown

(b) Address

1220 E. Monument St.

17 (a)

(b) Date thereof

9/11/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Oliver, Conn.

Location

A. C. C.

18 (a) Funeral director

R. J. C. Williams

(b) Address

1515 McElderry St.

19 (a)

SEP 10 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1220 E. Monument St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1943 19 at 8:45 M

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. J. Wollenweber M.D.

Date signed 9-8-43 Ant Medical Examiner.

G 08034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 08034

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1205 W Lankale St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1205 W Lankale St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Clarence Boone Jr

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

Coloured

6 (a) Single, married, widowed, or divorced.

Child

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Aug 27, 1911

8. AGE:

Years

Months

Days

If less than one day

1941

2

11

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Clarence Boone Sr

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Jannine Stennette

15. Birthplace

Baltimore

16 (a) Informant

Clarence Boone Jr

(b) Address

1205 W Lankale St

17 (a)

Burial

(b) Date thereof

9-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

3rd & E to Md

18 (a) Funeral director

Isaiah L. Brown Jr

(b) Address

108 W Montgomery St

19 (a)

SEP 10 1943

Huntington Williams, Jr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 8 1943, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/27 1943 to 9/17 1943.

and that I last saw him alive on 9/16 1943.

Immediate cause of death

Acute gastroenteritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

113 Haverhill St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08035

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1007 Booth St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1904

8. AGE: Years Months Days If less than one day

39

4

17

hr.

min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation Brickyard Work

11. Industry or business General Reflector

12. Name John

13. Birthplace N. C.

14. Maiden Name Mattie Tate

15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sept 10, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory Charlotte N. C.

Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Broadway St.

19 (a) SEP 10 1943

VB 144

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1943 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1943 to 9-6 1943

and that I last saw him alive on 9-6 1943

Immediate cause of death

Due to Pneumonia
Peritonitis

Due to Intestinal Obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-28-43

Major findings of operations adhesion

of autopsy: none

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald A. Seft

Address Baltimore Hosp Date signed 9-7-43

Duration

1 wk
1 wk

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08036
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *11 1/2 Penn St.*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) *4*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County
(c) City or town *Balto.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *11 1/2 Penn St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Temple Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 1943

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

J. Fred. Willis

13. Birthplace

B. Bay

14. Maiden Name

Pearl Bates

15. Birthplace

Balto. Md.

16 (a) Informant

Pearl B. Willis

(b) Address

11 1/2 Penn St.

17 (a) *Burial*

(b) Date thereof

Sept. 10, 1943

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

St. Aulmar am.

Location

18 (a) Funeral director

Mrs. Katie R. Williams

(b) Address

322 N. Schroeder St.

19 (a)

SEP 10 1943

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-8-1943* at *4 A* M

21. I certify that death occurred on the date above stated that I attended deceased from *9/6* 1943 to *9/8* 1943 and that I last saw her alive on *9/7* - 1943.

Immediate cause of death

Enter - Pleuro

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

Means of injury

23. Signature

B. J. Halch

Address

12 N. Penn St.

Date signed

9/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ G 08037
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address:
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) *home*
(e) Length of stay in Baltimore (yrs., mos., or days) *1 year*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md.* (b) County:
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2005 Belvoir Rd*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country:

3 (a) FULL NAME
Julia Martha Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *female* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced *divorced*
6 (b) Name of husband or wife *James W. Brown*
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) *April 9-1886*
8. AGE: Years Months Days If less than one day
57 4 28 hr. min.

9. Birthplace *Germany*
(Town, county, and state)
10. Usual Occupation *at home*
11. Industry or business

FATHER
12. Name *Martin Richter*
13. Birthplace *Germany*
MOTHER
14. Maiden Name *Anna*
15. Birthplace *Germany*

16 (a) Informant *Richard Klesch*
(b) Address *Cleeland, Md*
17 (a) *Burial* (b) Date thereof *Sept 11-1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Angel Hill*
Location *Harry de Grace, Md*
18 (a) Funeral director *Burial in home*
(b) Address *3631 Falls Rd*

SEP 10 1943

VB 154

MEDICAL CERTIFICATION
20. DATE OF DEATH *9/7/43* 19 *12:00 P. M*
21. I certify that death occurred on the date above stated; that I attended deceased from *9/7* 19 *43*, to *19*, and that I last saw her alive on *9/7* 19 *43*.

Immediate cause of death *Cerebral Hemorrhage*
Due to *Hypertensive heart disease*
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *Nathan E. B. Reed*
Address *St. Joseph's Hospital* Date signed *9/10/43*
W. S. Williams

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08038
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4322 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4322 Falls Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

George Munzer

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-01-2336

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Grace Lee Munzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17-1878

8. AGE: Years 64 Months 9 Days 22
If less than one day hr. min.

9. Birthplace Baltimore, Md.
(City, county, and state)

10. Usual Occupation Painter

11. Industry or business

12. Name John Adam Munzer

13. Birthplace Germany

14. Maiden Name Elizabeth Golden

15. Birthplace Maryland

16 (a) Informant Mrs. Grace Lee Munzer

(b) Address 4322 Falls Road

17 (a) Burial (b) Date thereof Sept. 13, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's (Roman Catholic)

Location Baltimore, Md.

18 (a) Funeral director Surge's Funeral Home

(b) Address 2631 Falls Road

19 (a) SEP 10 1943 (b) Address Huntington Williams, M.D.
(Date rec'd by registrar) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1943, at 1:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 9/9, 1943, and that I last saw him alive on 9/9, 1943.

Immediate cause of death

Chronic valvular heart
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harold W. Hoff

Address 20204 Charles Date signed 9/10/43

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08039

136

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1603 N. Bradford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1603 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

John Schwingenberg

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 214-03-1345

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mary Schwingenberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 5, 1880

8. AGE:

Years

Months

Days

If less than one day

63

01

3

hr. min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Screen Chaser

11. Industry or business

S. Kunk & Son

FATHER

12. Name

August Schwingenberg

MOTHER

13. Birthplace

Germany

14. Maiden Name

Augusta

15. Birthplace

Germany

16 (a) Informant

Mary Schwingenberg

(b) Address

1603 N. Bradford St

17 (a) Burial

Burial

(b) Date thereof Sept 11 1943

(c) Cemetery or crematory

B. G. L. Cemetery

Location

E. North Ave. E. 1st

18 (a) Funeral director

Les. S. L. S. Co.

(b) Address

701-03 N. Pratt Park Ave

19 (a) Date of death

Sept 10 1943

(b) Registrar

Therese Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 8 1943 at 10 30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1943 to Sept 8 1943

and that I last saw him alive on Aug 8 1943

Immediate cause of death

Pneumonia Tuberculosis

Duration

4 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Thos. S. L. S. Co.

Address

2878 Harford Ave

M. D.

Sept 9 1943

SEP 10 1943

VS 150

08040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08040

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 621 N. Spring St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME HATTIE RICHARDS ELLIOTT NEE GREEN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Cul

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1870

8. AGE: Years

73

Months

Days

If less than one day

hr.

min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER12. Name James Hinton13. Birthplace Baltimore Md.14. Maiden Name Annie Brown15. Birthplace Maryland16 (a) Informant Richard Hinton(b) Address 621 N. Spring St17 (a) Burial (b) Date thereof 10 11 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutusman Park
Location Baltimore Md18 (a) Funeral director Mrs Ida Bailey(b) Address 1421 Jefferson St19 (a) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1943, at 4:50 PM21. I certify that I took charge of the remains described above, held an
inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carcinoma of rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature H. W. G. Williams M.D.
Medical Examiner.Date signed 9-8-43

SEP 10 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 08041

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4509 Penhurst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr. Clarence Clifton Oursler

3 (b) If veteran, name war
none

3 (c) Social Security Account
No.

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife Susie Rosella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1890

8. AGE: Years Months Days If less than one day
63 4 26 hr. min.

9. Birthplace Manchester, Md.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business J. F. Obrecht

12. Name Edward Oursler

13. Birthplace Md.

14. Maiden Name Juliann Weaver

15. Birthplace Pa.

16 (a) Informant Mr. C. L. Oursler

(b) Address 4509 Penhurst Ave.

17 (a) burial (b) Date thereof 9/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory,
Location Manchester, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 SEP 10 1943 (b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1943, at M

21. I certify that death occurred on the date above stated; that I attended
deceased from 1942 to Sept 7 1943.
and that I last saw him alive on 19

Immediate cause of death

Cocaine of Green
secondary to
Cocaine of Green
Due to fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

Means of injury

23. Signature A. C. Smith
Address 4209 Liberty Highway

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08042

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 819 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W. Lexington St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3 (a) FULL NAME

Ella Mae Burley nee Nelson

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex
F

5. Color or race
C

6 (a) Single, married, widowed, or divorced
Separated

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/1880

8. AGE: Years Months Days If less than one day
62 63 9 3 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Edward Burley

13. Birthplace Md

14. Maiden Name Indiana Adams

15. Birthplace Balt. Md.

16 (a) Informant Annie Wells (Daughter)

(b) Address 819 W. Lexington St.

17 (a) Burial (b) Date thereof 9/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Chas. S. Cooper

(b) Address 514 N. Calhoun St.

19 (a)

SEP 10 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/43 12:10 PM

21. I certify that death occurred on the date above stated, that I attended deceased from [signature] and that I last saw him alive on [signature]

Due to [signature] Duration 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify place)

(e) Means of injury

23. Signature [signature]

Address [signature] Date signed 9/9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08043

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08043

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

222 Myrtle Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4 Sex

Male

5 Color or race

Negro

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

46

Months

6

Days

24

If less than one day

hr.

min.

9. Birthplace

Hampton Va

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

VS 1

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

State

County

City or town

Street No.

Citizen of foreign country?

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

Signature

Address

Date signed

23. Signature

Address

Date signed

24. Signature

Address

Date signed

25. Signature

Address

Date signed

26. Signature

Address

Date signed

27. Signature

Address

Date signed

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

Signature

Address

Date signed

23. Signature

Address

Date signed

24. Signature

Address

Date signed

25. Signature

Address

Date signed

26. Signature

Address

Date signed

27. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08044

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 908
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Agnes Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1942

8. AGE: Years 109 Months 39 Days 39 If less than one day
hr. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Samuel W. Sullivan

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Viola A. Parker

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mr. Samuel W. Sullivan

(b) Address

908 Lemon St.

17 (a)

burial (b) Date thereof 9/9/43
(month) (day) (year)

New Catholic Cemetery
(c) Cemetery or crematory

Location

901 1/2 E. St.

18 (a) Funeral director

John J. Brown

(b) Address

901 1/2 E. St.

19

SEP 10 1943

William M. J.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1943 at 10:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1943 to 9/9 1943, and that I last saw him alive on 9/9 1943.

Immediate cause of death

Severe aneurysm

Due to

Extreme dehydration

Due to

Severe (spontaneous)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

W. Cohen

Address

University Ave

Date signed

9/10/43

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08045

BALTIMORE CITY HEALTH DEPARTMENT

✓ G 08045

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4901 Roland Ave.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4901 Roland Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.

3 (a) FULL NAME Susan O'Donnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1868

8. AGE: Years Months Days If less than one day
74 10 13, 2 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

12. Name Neill O'Donnell

13. Birthplace Baltimore, Md.

14. Maiden Name Mary E. Quinn

15. Birthplace Md.

16 (a) Informant Marion F. Baker

(b) Address 3044 Guilford Ave.

17 (a) Burial (b) Date thereof 9/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ecclesiastical New Cathedral

Location Old Frederick Rd., Ealto., Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 SEP 10 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1943 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1943 to Sept 9th 1943, and that I last saw him alive on Sept 9th 1943.

Immediate cause of death

Coronary Thrombosis

Due to Anterior Myocardial Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. O. Mitchell

Address 1302 N. Calvert St. Date signed M. D.

The information furnished on this certificate is for statistical purposes only and should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08046

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Cremation

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1943, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 8 1943 11 A.M.

(b) Where did injury occur 5200 Block Liberty Ave., Alameda

(c) Did injury occur at home, on farm, industrial place, in public place? Road While at work? No

(d) Means of injury auto struck telegraph pole

23. Signature Robert Lee Graham M.D.

Date signed Sept. 8 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

440736
G 08047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08047
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1015 Stiles
(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Anthony Di Pietro

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 215-14-9682

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4-1-21

8. AGE:

Years

Months

Days

If less than one day

22

5

7

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Helper on Ship Yard

11. Industry or business

FATHER
MOTHER

12. Name

Rocco Di Pietro

13. Birthplace

Italy

14. Maiden Name

FANNIE JULINNO

15. Birthplace

Italy

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof Sept. 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Cemetery

Location

Belair Rd. Baltimore Md.

18 (a) Funeral director

Frank Della Noce

(b) Address

52 N. Morley St.

19 (a)

(b) Huntington Williams, M.D.

SEP 10 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1943 at 12:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1943 to Sept 8 1943 and that I last saw him alive on Sept 8 1943.

Immediate cause of death Brain Abscess

Due to 01
Of Oss of Femur

Due to

Other Conditions Congenital Heart

(Include pregnancy within 3 months of death)

Date of operation 7-7-43

Major findings of operations Brain abscess

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Hugo V. Ruggli

Address Hugo V. Ruggli

Date signed 9-8-43

John Hopkins Hosp.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08048

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 130

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 528 N. Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? No (Yes only)
If yes, name country

3 (a) FULL NAME

Vincenzo Di Nicolo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Anna Di Nicolo

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 29 - 1866

8. AGE: Years Months Days If less than one day
77 4 11 hr. min.

9. Birthplace Cernignano Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Clothing

12. Name Dominico Antonio di Nicolo

13. Birthplace Cernignano Italy

14. Maiden Name Francesca Forcella

15. Birthplace Cernignano Italy

16 (a) Informant Anthony Di Nicolo

(b) Address 5636 Iberville Ave.

17 (a) Burial (b) Date thereof Sept 11-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md.

18 (a) Funeral director Graff Della Rose

(b) Address 52 N. Morley St.

19 (a) (b)

(Date rec'd by registrar) (Registrar)
10 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 - 1943 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5-1943 to 9-9-1943, and that I last saw him alive on 9-7-1943.

Immediate cause of death

Acute Nephritis

Duration

unknown

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chester Piland

Address 2532 Edmondson Ave Date signed 9-9-43 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4449 28019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08019

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

1 day

3 (a) FULL NAME

Dr. Lewis Goldstone

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr 16-09

8. AGE:

Years

Months

Days

If less than one day

34

4

25

hr.

min.

9. Birthplace

Maine

(Town, county, and state)

10. Usual Occupation

Dentist

11. Industry or business

MOTHER FATHER

12. Name

Abraham Goldstone

13. Birthplace

Lith.

14. Maiden Name

Dusque Birman

15. Birthplace

Lith.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

Removal & Burial

Date thereof 9/10/09

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Boston, Mass.

18 (a) Funeral director

David Lowenstein

(b) Address

1942 Eastway Place

Washington, D.C.

(c) Registrar

Registrar

SEP 10 1909

VS 140

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mass

(b) County

(c) City or town

Dorchester, Mass.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

121 Norfolk St

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 10 1943 at 11:25

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 9 1943 to Sept 10 1943

and that I last saw him alive on Sept 10 1943.

Immediate cause of death

Brain tumor

Rt frontal lobe, glioma

malignant

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Sept 10, 1943

Major findings of operations

Brain tumor

of autopsy:

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm. V. Rydell

Address

Johns Hopkins Hospital

M. D.

Date signed

Sept 10, 1943

G 08050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08050

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert St.

(c) Hospital or institution:

MERCY HOSP.(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.(e) Length of stay in Baltimore (yrs., mos., or days) 4705

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 318 N. Pearl St.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

James Clarence Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4/19/43

8. AGE:

Years

Months

Days

If less than one day

420

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name James Clarence Campbell13. Birthplace Balto., Md.14. Maiden Name Margaret Siatsing15. Birthplace Richmond Va.

16 (a) Informant

(b) Address

Mary Hospital
Calvert Street

17 (a)

Burial(b) Date thereof Sept 11-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral CemeteryLocation Old Frederick Road

18 (a) Funeral director

Joseph Farace Inc.

(b) Address

1019 10th Ave

19 (a)

Baltimore, Md.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/919 43 at 7:25 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 19 43 to 9/9 19 43.and that I last saw him alive on 9/9 19 43.

Immediate cause of death

Pneumonia - Diarrhea

Duration

3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Mercy HOSP. Date signed 9/9/43

M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08051

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert Williams Ave*

(c) Hospital or institution:

Saint Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 2 1*

(e) Length of stay in Baltimore (yrs., mos., or days) *0*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *Harford*

(c) City or town *Aberdeen*
(If outside city or town limits, write RURAL and give town)

(d) Street No. _____
(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country _____

3 (a) FULL NAME

3 (b) If veteran, name war _____

3 (c) Social Security Account
No. _____

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife *Amos Slide*

6 (c) If alive, give age *55* years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

53

1

28

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *Dr. Fenton*

(b) Address *Optum Rd*

17 (a) *Burial*
(Burial, cremation, or removal)

(b) Date thereof *Sept. 12, 1943*
(month) (day) (year)

(c) Cemetery or crematory *Southern M.C.*

Location *Dublin, Harford Co., Md.*

18 (a) Funeral director *Henry T. Davis, Inc.*

(b) Address *Aberdeen, Md.*

SEP 10 1943

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 9* 1943, at *8 P* M

21. I certify that death occurred on the date above stated; that I attended deceased from *9/3* 1943, to *9/9* 1943, and that I last saw him alive on *9/9* 1943.

Immediate cause of death

Pulmonary embolism

Due to *Renal thrombosis*

Due to *Post operative*

phlebitis

Other Conditions *hypertension*

for metrorrhagia

(Include pregnancy within 3 months of death)

Date of operation *9/4/43*

Major findings of operation: *large, boggy*

uterus

of autopsy: *Pulmonary embolism*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State) @

(d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury _____

23. Signature *Howard W. Stier*

Address *St Agnes Hospital* Date signed *9/9/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

08052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08052
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1218 N. Charles Street
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ---
If yes, name country ---

3 (a) FULL NAME

HELEN WILLIAMS

Helen Rowe Williams

3 (b) If veteran, name war ---

3 (c) Social Security Account
No. 239-09-2421

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th 1904

8. AGE:

Years

Months

Days

If less than one day

39

2

14

hr.

min.

9. Birthplace Rockingham County, N. C.

(Town, county, and state)

10. Usual Occupation

Typist

11. Industry or business Glenn L. Martin Co.,12. Name Walter J. Williams13. Birthplace Rockingham County, N. C.14. Maiden Name Jennie Crawford15. Birthplace Forsythe County, N. C.16 (a) Informant Hanes Funeral Home(b) Address Greensboro, N. C.17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof Sept 10th 1943

(month) (day) (year)

(c) Cemetery or crematory

Location Greensboro, N. C.18 (a) Funeral director Wm. J. Tickner & Sons(b) Address North & Perna Aves.

SEP 10 1943

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1943 at 9:45 A. M21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Pneumonia lobular. Cause undeterminedDue to Pending investigation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. W. Williams M.D.Date signed 9-10-43

08053

ROGERS BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

G 08053

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 11 1943

VS 124

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1943 to 9/9 1943, and that I last saw him alive on 9/9 1943.

Immediate cause of death

Due to

Due to

Other Conditions

Cause?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08054

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08054

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4032 Lewiston Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4032 Lewiston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LorettaSilkworth

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W6 (a) Single, married, widowed, or
divorced.married

6 (b) Name of husband or wife

Paul D. Silkworth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 31, 1890

8. AGE:

Years

Months

Days

If less than one day

5377

hr.

min.

9. Birthplace

Richmonds, Va.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Carter Jett.

13. Birthplace

Richmond, Va.

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mrs. Amber Taylor

(b) Address

4032 Lewiston Ave

17 (a)

Burial

(b) Date thereof

9-11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Good Sheppard

Location

Rockland, Md.

18 (a) Funeral director

Loring Byers

(b) Address

5005 Park Heights Ave

19 (c)

SEP 11 1943Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1943, at 7:15 AM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cerebralocclusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert L. Graham M.D.

Date signed

Sept. 7 1943

G 08055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08055

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3440 Reisterstown Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3440 Reisterstown Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CAROLINE RIEBEL

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Frederick N. Riebel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8.31.1868

8. AGE: Years Months Days If less than one day

75

0

9

hr.

min.

9. Birthplace Shady Side, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name -- Griner

13. Birthplace Maryland

14. Maiden Name Sophie East

15. Birthplace Md.

16 (a) Informant Mr. F. N. Riebel

(b) Address 3440 Reisterstown Rd.

17 (a) Burial (b) Date thereof 9/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a)

SEP 11 1943

Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1943, at 5:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1943, to Sept. 10 1943 and that I last saw her alive on Sept 9 1943.

Immediate cause of death Coronary thrombosis

Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arthur W. KAC M. D.

Address 3862 Osfield Ave. signed 9-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08056

BALTIMORE CITY HEALTH DEPARTMENT

G 08056

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 831 N. Eutaw St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 831 N. Eutaw St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

JAMES A. CHALK

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or divorced.
married

6 (b) Name of husband or wife Margaret I. Chalk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1962

8. AGE: Years	Months	Days	If less than one day
80	9	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name James Alexander Chalk

13. Birthplace Maryland

14. Maiden Name Sophie Beck

15. Birthplace Germany

16 (a) Informant Mrs. Margaret I. Chalk

(b) Address 831 N. Eutaw St.

17 (a) Burial (b) Date thereof 9/11/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) SEP 11 1943

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1943, at 1:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28, 1943, to Sept. 9, 1943, and that I last saw him alive on Sept. 9, 1943.

Immediate cause of death

Due to Chronic Hepatitis 1 year

Due to Acute Insufficiency 5 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. K. Pettit Date signed M. D.

Address 817 Hamilton St.

H. K. Pettit

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08057

Registered No. 78

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

728 Bruce St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

54 yrs

3 (a) FULL NAME

Sarah J. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Rev. J. H. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-3-1876

8. AGE: Years

67

Months

Days

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

own home

FATHER

12. Name

Henry Thompson

13. Birthplace

md

14. Maiden Name

Anne P

15. Birthplace

md

16 (a) Informant

Wesley A. Martin

(b) Address

1015 N. Calhoun St.

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

9-12-43

(c) Cemetery or place of interment

Mt. Auburn Cem

Location

Baltimore MD

18 (a) Funeral director

William A. Jackson

(b) Address

916 Penna ave

19 (a)

SEP 11 1943

(Date of registration)

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

728 Bruce St

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-9-1943

at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8-29-1943 to 9-9-1943.

and that I last saw her alive on 9-8-1943.

Immediate cause of death

Nephritis

Duration

Unknown

Due to

Due to

Other Conditions

Hypertension and

myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Frank A. Saunders

M. D.

Address 1029 N. Street St. Date signed 9-13-43

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08058

BALTIMORE CITY HEALTH DEPARTMENT

G 08058

CERTIFICATE OF DEATH *119a*

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1400 S Caroline St*

(c) Hospital or institution:

St. Joe. Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 hrs*(e) Length of stay in Baltimore (yrs., mos., or days) *2 mos*

3 (a) FULL NAME

Rodney Gear

3 (b) If veteran, name war

(c) Social Security Account

No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 4, 1943

8. AGE: Years Months Days

If less than one day

hr.

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Olin Russel Gear

13. Birthplace

Millers W Va.

14. Maiden Name

Bella Cutright

15. Birthplace

Millers W Va.

16 (a) Informant

M. O. R. Gear

(b) Address

*296 Mason Ct*17 (a) *Burial*

(b) Date thereof

Sept 11 43

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Cemetery or crematorium

First United Co.

Location

Chrysell St

18 (a) Funeral director

Seemann & Son

(b) Address

32 S. Broadway

19 (a)

SEP 11 1943

(Date of registration)

Registrar

Huntington Williams, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

296 Mason Ct

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9-10-1943 at 4:25 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *9-10-1943 2:30 PM* to *9-10-1943 4:25 PM*and that I last saw him alive on *9-10-1943*Immediate cause of death *Dehydration*

Duration

Due to *Diarrhea & vomiting**1 week*Due to *Nonspecific Cause*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William J. Hays

M. D.

Address

St. Joseph's Hosp

Date signed

9/11/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08059

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, ~~widowed~~ or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 11 1943

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 8:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1943 to 9/8 1943 and that I last saw her alive on 9/8 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08060

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 Mc Biddle St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

PAULA LEE CHESTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1943

8. AGE:

Years

Months

Days

If less than one day

2

1

27

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name Paul Chester

13. Birthplace Baltimore, Md.

14. Maiden Name Georgeanna McMechan

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Georgeanna Chester

(b) Address

17 (a) Burial

(b) Date thereof 9-11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Balto., Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 578 W? Biddle St.

19 (a)

(b)

SEP 11 1943

Huntington Memorial

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1943, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1943 to Sept 10 1943, and that I last saw her alive on Sept 10, 1943.

Immediate cause of death

Malnutrition

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2243 Madison Ave. Date signed 9-11-43

M. D.

Duration

10 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08061

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Madison + Howard St*
(c) Hospital or institution:
Mad. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 hours*
(e) Length of stay in Baltimore (yrs., mos., or days) *0*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *Anne Arundel Co*
(c) City or town *Glen Burnie P.O.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *Marley Park*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Frances Eleanor Hyson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. *S*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 19 1942*

8. AGE: Years Months Days If less than one day
1 16 26 hr. min.

9. Birthplace *Glen Burnie*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Bennett Hyson*

13. Birthplace *Md.*

14. Maiden Name *Eleanor Baumbart(?)*

15. Birthplace *Md.*

16 (a) Informant *Mr. Bennett Hyson*

(b) Address *Marley Creek*

17 (a) *Burial* (b) Date thereof *9/11/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Cross*
Location *Baltimore Md*

18 (a) Funeral director *William M. Marek*

(b) Address *715 E. 1st St*

19 (a) *SEP 11 1943* (b) *Stuntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 9 1943* at *7:58 P*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 7 1943*, to *Sept 9 1943*, and that I last saw her alive on *Sept 9 1943*.

Immediate cause of death

Meningitis - probably meningococci

Due to

Due to

Other Conditions *Diarhea*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *E. H. Williams*

Address *Mad. Gen. Hosp.* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Sept 10, 1943

G 08062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08062
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
City Morgue

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Strickland Street
2613 SLOATFIELD AVE (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HENRY F. PRIEBE

3 (b) If veteran, name war

-

3 (c) Social Security Account
No. 219-07-8262

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Doris Priebe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 11, 19218. AGE: Years Months Days If less than one day
22 1 28 hr. min.9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Soldier -Co.B-84111. Industry or business U. S. Armer

FATHER

12. Name Henry F. Priebe, Leesburg, Florida.13. Birthplace Unknown

MOTHER

14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Doris Priebe(b) Address 2613 SLOATFIELD AVE17 (a) BURIAL (b) Date thereof 9-11-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St Pauls CmnLocation VIOLTSVILLE MD18 (a) Funeral director Mr Charles S. Polide(b) Address 2327 EDMONDSON AVE

19 (a) (b)

(Date of death) Registrar

SEP 11 1943 Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1943 at 1:45 P.M.21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

drowning, accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury Dec 27 1942 M.(b) Where did injury occur? harbor, falling(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work? —Means of injury drowning23. Signature J. W. Hollenback M.D.Date signed 9-9-43 Asst Medical Examiner.

08063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08063

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 216 E. Lake Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 E. Lake Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

DORA KUNKEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Joseph A. Kunkel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1882

8. AGE: Years Months Days If less than one day

61

4

14

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name John Becker

13. Birthplace Balto. Md.

14. Maiden Name Josephine Sellemayer

15. Birthplace Germany

16 (a) Informant Joseph A. Kunkel

(b) Address 216 E. Lake Ave.

17 (a) Burial (b) Date thereof 9/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto. Md.

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt. Royal Ave

19 SEP 11 1943 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

6 P.

20. DATE OF DEATH September 9, 1943, at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. W. Wollenmeyer M.D.

Date signed 9-10-43 Medical Examiner.

G 08064

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1705 Crystal Ave
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 8-16
 (e) Length of stay in Baltimore (yrs., mos., or days) 62-74

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1705 Crystal Ave
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

Theresa Stomer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Wm. F. Stomer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Aug. 10, 1864

8. AGE:

Years 79

Months 1

Days 0

If less than one day X X X X X min.

9. Birthplace

Germany
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
 MOTHER

12. Name

Eichner

13. Birthplace

Germany

14. Maiden Name

?

15. Birthplace

Germany

16 (a) Informant

Wm. V. Stomer

(b) Address

1705 Crystal Ave

17 (a)

Burial

(b) Date thereof

9/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore Md.

18 (a) Funeral director

George J. Smith Inc

(b) Address

1725 Maryland Ave

SEP 11 1943

Wm. V. Stomer
Wm. V. Stomer
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

SEP 10 1943 10:30 A-M

21. I certify that death occurred on the date above stated; that I attended deceased from SEP 6 1943 SEP 10 1943 and that I last saw h. SEP 10 1943

Immediate cause of death

General
Exhaustion due to
Broncho Pneumonia

Duration
4 days

Due to

Due to

Other Conditions

Chronic Myocarditis
Endocarditis

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation

None

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

no

(b) Date of occurrence

none

M

(c) Where did injury occur?

none

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? now While at work? none

(Specify type of place)

(e) Means of injury

23. Signature

Wm. V. Stomer

Address

928 E. North Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08065
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital Redwood & Green Sts. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 13 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)(d) Street No. University Hospital
Lacawanda Ave
(If rural give locality)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Infant of Viola Mellett

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

Viola none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-9-43

8. AGE: Years

13 mo.

Months

-

Days

-

If less than one day

13 mo.

min.

9. Birthplace

University Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

George Ray Mellett

13. Birthplace

The Connell Spring Co

14. Maiden Name

Viola Howard

15. Birthplace

Bay Mills, Md

16 (a) Informant

Mother

(b) Address

Viola Mellett

17 (a)

Burial

(b) Date thereof

Sept 11, 1943
(month) (day) (year)

(c) Cemetery or crematory

Providence Meth

Location

Baltimore Co. Md

18 (a) Funeral director

Lacawanda Funeral Home

19 (a)

SEP 11 1943

(b) Date rec'd by registrar

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-43 1943, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9-43 to 9-10-43, and that I last saw her alive on 9-10-43.

Immediate cause of death unknown.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Raymond E. Sample

Address

University

Date signed 9-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83-2 G 08066
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Kelkins + Caton Aves.*

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yes, mos., or days) *50*

(e) Length of stay in Baltimore (yes, mos., or days)

3 (a) FULL NAME

Charles W. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account

No. *258-12-0930*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Wife - Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *10-30-87*

8. AGE: Years Months Days If less than one day

55 *10* *11* *10* hr. min.

9. Birthplace *Detroit - Michigan*

(Town, county, and state)

10. Usual Occupation *Bar tender*

11. Industry or business

12. Name (See)

13. Birthplace *Canada*

14. Maiden Name *Indy*

15. Birthplace *Canada (See)*

16 (a) Informant *Mrs. Charles W. Roberts*

(b) Address *558 S. Rolling Road*

17 (a) *Burial* (b) Date thereof *Sept. 13, 1943*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Johns Cem.*

Location *Bellicott City, Md.*

18 (a) Funeral director *Epston Sons*

(b) Address *611 E. Baltimore St., Md.*

(c) Date of funeral *Sept. 14, 1943*

(d) Registrar

(e) Address

(f) Date of registration

(g) Signature

(h) Address

(i) Date of registration

(j) Signature

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Catonsville*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *558 S. Rolling Rd.*

(If give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 10* 19*43* at *5:00 PM*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *9-10* 19*43* to *9-10* 19*43*

and that I last saw him alive on *9-10* 19*43*

Immediate cause of death

Cerebral hemorrhage

Due to *Hypertension &*

Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Alfred Harrison*

Address *St. Agnes Hosp.* Date signed *9-10-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 11 1943

VS 114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

8087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08067

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2723 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Clement F. Butterfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Editha Lacy Butterfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 24 1870

8. AGE:

Years

Months

Days

If less than one day

72

8

17

hr.

min.

9. Birthplace

Baltimore Md

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Rodolph Butterfield

13. Birthplace

West India

14. Maiden Name

Mary E Mac-Donald

15. Birthplace

Canada

16 (a) Informant

Editha Lacy Butterfield

(b) Address

2723 N. Charles St

17 (a)

Burial

(b) Date thereof 9/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Bm

Location

Edmondson Ave

18 (a) Funeral director

John A. Moran

(b) Address

3000 E. Baltimore St

SEP 11 1943

(b)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to Sept 10 1943. and that I last saw him alive on Sept 9 1943

Immediate cause of death

Coronary Thrombosis

Duration

3 days

Due to Generalized Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

none

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

Signature Nathaniel M. Brook

Address 2727 N. Charles Date signed Sept 12 1943

Age is especially important. Physicians: please write the causes of death clearly and legibly.

08068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08068
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1707 David Hill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

3 (a) FULL NAME

Frances Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

negro

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

John Sadler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

63

hr.

min.

9. Birthplace

Charlotte N.C.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Dock Pennington

13. Birthplace

Charlotte N.C.

MOTHER

14. Maiden Name

Ross

15. Birthplace

Julius Pennington

16 (a) Informant

541 Polphing St

(b) Address

17 (a) Burial

(b) Date thereof

Sept. 11, 1943

(c) Cemetery or crematory

977 Auburn Cem

Location

18 (a) Funeral director

W. K. P. Williams

(b) Address

3924 Lombard St.

19 SEP 11 1943

W. K. P. Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1707 David Hill Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 8

1943 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 4-6-43 19 to 9-8-43 19

and that I last saw her alive on 9-8-43 19

Immediate cause of death

Cerebral Hemiplegia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

1632 David Hill Ave

Address

9-11-43

9-11-43

9-11-43

9-11-43

9-11-43

9-11-43

9-11-43

9-11-43

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9-11-43

G 08069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08069

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 43, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 19 43 to 9/11 19 43, and that I last saw him alive on 9/10 19 43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/11/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PRINTED IN PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08070

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 223 S. Pulaski St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 223 S. Pulaski St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Meyer Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Anna Marie Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

September 17-1870

8. AGE: Years

72

Months

11

Days

13

22

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Butcher

11. Industry or business

Retired

12. Name

Carl Meyer

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany

16 (a) Informant

Charles Meyer Jr.

(b) Address

223 S. Pulaski St.

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western

Location

Baltimore Md.

18 (a) Funeral director

George F. Schwalbe

(b) Address

2101 E. Frederick Ave

19 (a) 9/11/43

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1943, at M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from July 1943 to Sept 9 1943.

and that I last saw him live on Sept 7 1943.

Immediate cause of death

Coronary thrombosis

Due to

Generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Schwalbe

Address

2501 Campbell St

Date signed

9/11/43

G 08071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08071
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LOUIS H. LEVY

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1927

8. AGE: Years Months Days If less than one day
16 hr. min.

9. Birthplace

New York City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Sidney Levy13. Birthplace New York14. Maiden Name Betty Silverman15. Birthplace New Jersey

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof 9-12-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory BowdoinLocation Phil Ryle Hamlet, Arundel

18 (a) Funeral director

(b) Address

Joe S. Lewis Inc.
1439 E. Pratt St.

SEP 12 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION 9:15 A.

20. DATE OF DEATH September 10, 1943 at M21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Crushing of right chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury Sept. 9, 1943 11:30 P. 15/5(b) Where did injury occur? Carlins Park(c) Did injury occur at home, on farm, industrial place, in public
place? Public Place While at work? No(d) Means of injury While standing on the running
board of racer dip he fell off.23. Signature W. J. Williams M.D.Date signed 9-10-43

Direct age is especially important. Physicians: please write the causes of death clearly and legibly. The system of information should be carefully supplied.

G 08072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08072
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th Street

(c) Hospital or institution: Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 8 1/2 yrs

3 (a) FULL NAME

Mrs. Emma Voeke

3 (b) If veteran, name war

3 (c) Social Security Account

No. 1-126

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife George H. Voeke Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1853

8. Age at death

90

90

90

If less than one day

hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Adolph Limon

13. Birthplace Baltimore

14. Maiden Name Margaret Toney

15. Birthplace Baltimore

16 (a) Informant Home for Incurables

(b) Address 700 W. Fortieth Street

17 (a) Cause of death (b) Date thereof 9/13/43

(c) Cemetery, crematory Green Mount

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

19 (a) Date of death 9/13/43

19 (b) Date of death 9/13/43

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th Street

(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1943 19 Y3. 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to Sept 11th 1943, and that I last saw him alive on Sept 9th 1943.

Immediate cause of death

Acute Myocardial Infarction (Re. Pulmonary Edema)

Due to Hypertensive Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas Conrad Welf

Address 11 E. Ches. St.

Date signed 9/11/43

Duration

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

10 years

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08073

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2840 Oakley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Isaac Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865
8. AGE: Years 78 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

12. Name Gerson Henderson

13. Birthplace Russia

14. Maiden Name Unkown

15. Birthplace Russia

16 (a) Informant. John Henderson

(b) Address 2840 Oakley Ave

17 (a) Burial (b) Date thereof Sept, 12, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory He brew Rosedale Cem.
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1943, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Sept 10, 1943, and that I last saw him alive on Sept 10, 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Atherosclerosis

Due to

Other Conditions

Localized Gangrene left toe.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 1206 E. Preston St. Date signed 9/14/43

Duration Sudden

?

4 X-ray
PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 12 1943

G 08074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08074
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Frederick Avenue St*
 (c) Hospital or institution: *Bon Secours Hosp*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Baltimore*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *453 Brunswick St*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Miss Clara Steinacker

3 (b) If veteran, name war

3 (c) Social Security Account

No. *214-18-7646*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

*July 10-1921*8. AGE: Years Months Days If less than one day
22 2 29 - hr. - min.9. Birthplace *Baltimore, Md*

(Town, county and state)

10. Usual Occupation *Sales Lady*11. Industry or business *Krupps Dept Store*12. Name *Ronald B. Steinacker*13. Birthplace *Baltimore, Md*14. Maiden Name *Grace Reichbach*15. Birthplace *Baltimore, Md*16 (a) Informant *Grace Steinacker*(b) Address *453 Brunswick St*17 (a) *Burial* (b) Date thereof *9/13/43*

(Burial, cremation, or removal) (month, day, year)

(c) Cemetery or crematory *London Park*Location *Baltimore, Md*18 (a) Funeral director *F. D. WIPPERT-SON*(b) Address *300 Eutan Place*(b) *Huntington, Williams, Md*

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-9-43* 19 *43* *PM*21. I certify that death occurred on the date above stated; that I attended deceased from *9-2* 19 *43* to *9/9* 19 *43*, and that I last saw her alive on *9/9* 19 *43*Immediate cause of death *Generalized Peritonitis* Duration *6 days*Due to *Secondary Closure of* *Old Post Operative Fecal* *Disturbance* *6 days*

Other Conditions

(Include pregnancy within 6 months of death)

Date of operation *9/3/43*Major findings of operation: *Old Post Operative Fecal Disturbance*of autopsy: *No Autopsy Done*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Edward J. Jones*Address *Bon Secours Hosp* Date signed *9-9-43*

SEP 12 1943

VS 3

G 08075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

✓ G 08075

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 835 Brinkwood Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Emma F. Ahrling

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Nov 1 - 1855

8. AGE: Years Months Days If less than one day

87 10 9 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Furniture

12. Name Herman Ahrling

13. Birthplace Germany

14. Maiden Name Anna Pellage

15. Birthplace Germany

16 (a) Informant Emma F. Ahrling

(b) Address 835 Brinkwood Road

17 (a) Burial (b) Date thereof Sept 13 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Cedar

18 (a) Funeral director M. Mrs. John W. Gensel & Son

(b) Address 801 N. Fayette St

19 (a) Date of registration SEP 13 1943 (b) Registrar William Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 835 Brinkwood Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1943, at 4⁴⁵ P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Aug. 14 1943 to Sept 10 1943 and that I last saw him alive on Sept 10 1943.

Immediate cause of death

Due to Chronic Myocarditis several years.
Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, or public place? While at work? (Specify type of place)

(e) Means of injury Injured by C. Plake

23. Signature M. D.

Address Med. Art. Bldg. signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) State Ark (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2216 Rushen Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

If yes, name country

MEDICAL CERTIFICATION

3 (c) Social Security Account No.

6 (a) Single, married, widowed, or divorced.

MARRIAGE

6 (c) If alive, give age _____ years

B. AGE:	Years	Months	Days	If less than one day
----------------	--------------	---------------	-------------	-----------------------------

62 1 13 hr. min.

(Town, county, and state)

11. Industry or business

PA 13. Birthplace GERMANY

15. Birthplace

(b) Address 2216 RUSKIN AVE

17 (a) BURIAL (b) Date thereof 9/13/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

(b) Address 1001 E. Roma Ave

12 1943 (Date rec'd by *John P. Williams*)

20. DATE OF DEATH Sept 10 2 1943, at 11 50 AM

21. I certify that I took charge of the remains described above, held an ~~inquiry~~ inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of mouth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) **Where did injury occur?**

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) **Means of injury.**

23. Signature H. Z. Wallenwahr M.D.

Date signed 9-10-83

PRINTED WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08077

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2918 Baker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 2918 Baker St.

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILHELMINA MATILDA FRANZ

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. no

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife Karl Franz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1866

8. AGE: Years Months Days If less than one day

77

1

0

hr.

min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name

Holzappel

13. Birthplace Germany

14. Maiden Name Klinesorger

15. Birthplace Germany

16 (a) Informant Mr. Paul F. Franz

(b) Address 2918 Baker St.

17 (a) Burial

(b) Date thereof 9/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location

Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

SEP 12 1943

(b) *Thurston Hill*

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1943, at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5-1943 to 9-11-1943 and that I last saw him alive on 9-11-1943.

Immediate cause of death

Coronary Thrombosis

Due to *Atherosclerosis*

Due to

Other Conditions *Hypertension Embolus to Left Leg*
(Include pregnancy within months of death)

Date of operation

Major findings of operation:

of autopsy: *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Leon Perlman

M. D.

Address 1291 *1914 Ave* Date signed 9-11-43

7 days

7 years

24 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08079

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4206 Kelway Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4206 Kelway Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MADELINE F. WELLS

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or

divorced. married

6 (b) Name of husband or wife Nelson E. Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1896

8. AGE: Years

47

Months

1

Days

10

If less than one day

hr.

min.

9. Birthplace Nelson E. Wells

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Frank H. Browne

13. Birthplace Charlestown, Mass.

14. Maiden Name Anna F. Dorton

15. Birthplace Charlestown, Mass.

16 (a) Informant Mr. Nelson E. Wells

(b) Address 4206 Kelway Rd.

17 (a) Removal (b) Date thereof 9/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Everett, Mass.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

SEP 12 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1943, at 6:00AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept. 9, 1943, to Sept. 11, 1943
and that I last saw her alive on 9/11/43

Immediate cause of death

Carcinoma Head of
Pancreas.

Due to

Due to

Other Conditions Carcinomatosis 2 mos.

(Include pregnancy within 3 months of death)

Date of operation Yes, ?

Major findings of operation:

Carcinoma Head of Pancreas

of autopsy:

Duration
6 mos.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Cockeysville, Md. Date signed 9/11/43

Physician: please write the causes of death clearly and legibly.

08080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08080
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 W. University Park

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 100 W. University Park
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Stashin Dennis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife J. Donald Dennis

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec. 26th 1885

8. AGE: Years 57 Months 8 Days 16 1/2 hr. min.

9. Birthplace Lexington, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Richard S. Stashin

13. Birthplace Virginia

MOTHER

14. Maiden Name Martha Graham

15. Birthplace Virginia

16 (a) Informant J. Donald Dennis

(b) Address 100 W. University Park

17 (a) Burial (b) Date thereof Sept 13 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry M. Rankin Sons

(b) Address 23 E. Calverton Ave

19 (a) Registrar

20. DATE OF DEATH September 11th 1943 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1924 19 to Sept 11th 1943 and that I last saw him alive on August 19th 1943

Immediate cause of death
Coronary-artery disease
with atherosclerosis which was
due to my mother on August 19th at the
time of my last professional visit

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. M. Rankin

Address Balto, Md

Date signed Sept 14 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

EP 12, 1943

12

G 08081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08081

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 (a) Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1943 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2-1943 to 9-11-1943, and that I last saw him alive on 9-11-1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

Eclampsia in mother
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Please print name of deceased and cause of death clearly and legibly.

EP 12 1943

Huntington Williams, M.D.

G 08082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08082

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1413 Madison Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1413 Madison Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MISSOURI

FOWLKES

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife Willie Fowlkes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

55

hr.

min.

9. Birthplace

Crew, Virginia
(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

- housework

FATHER
MOTHER

12. Name

Destiny Marshall

13. Birthplace

Virginia

14. Maiden Name

Willie Crawley

15. Birthplace

Virginia

16 (a) Informant

Eva Wilson

(b) Address

1413 Madison Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Sept. 15-43
(month) (day) (year)

(c) Cemetery or crematory

Crew, Va.

Location

Va.

18 (a) Funeral director

Geo. G. Kelson

(b) Address

1303 Preston St

19

12-1943

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1943 at 2:30 PM

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of stomach

Due to

Other Conditions

No

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Wallenweber M.D.

Medical Examiner.

Date signed 9-12-43

08083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08083
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va (b) County(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)(d) Street No. 1005 Brookside Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LOUIS A. LATIMER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 231-03-3988

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 9, 1900

8. AGE:

Years

Months

Days

If less than one day

4322

hr. min.

9. Birthplace

Virginia

10. Usual Occupation

Merchant Seaman

11. Industry or business

Merchant Seaman

FATHER

12. Name

Rott Latimer

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Catherine M. Claub

15. Birthplace

Virginia

16 (a) Informant

Sidney A. Latimer

(b) Address

Norfolk Va

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

(month) (day) (year)

Sept 14, 1943

(c) Cemetery or crematory

Location

Norfolk Virginia

18 (a) Funeral director

Rott C. B. M. Walters

(b) Address

Pratt's Truck Co

19 (a)

(b) Date of death

Sept 12, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11, 1943, at 5:45 PM21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 9-11-43 at 5:30 P. M.(b) Where did injury occur? Freemont Ave &(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no(d) Means of injury Revolver - shot while23. Signature W. A. Wallenmeyer M.D.Date signed 9-12-43Walking along street

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08084 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08084

Registered No. 2698

82a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 309 Calhoun St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 309 Calhoun St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Sarah Henderson

3 (b) If veteran, name war

3 (c) Social Security Account

No. 7776

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female Colored

Widowed

6 (b) Name of husband or wife Lloyd Henderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1882

8. AGE: Years Months Days If less than one day

60

9

27

hr.

min.

9. Birthplace Northumberland Co Va

(Town, county, and state)

10. Usual Occupation Janitress

11. Industry or business School 119

12. Name Perry Downing

13. Birthplace Va

14. Maiden Name Madelon Haynie

15. Birthplace Va

16 (a) Informant Mrs Ernestine Baxter

(b) Address 309 Calhoun St.

17 (a) Burial, cremation, or removal

(b) Date thereof Sept. 12, 1943

(c) Cemetery or crematory Laurel Cem.

Location Baltimore, Md.

18 (a) Funeral director Mr. George W. Waller

(b) Address 1434 Duval St. S.E.

(c) Address 1434 Duval St. S.E.

(d) Address 1434 Duval St. S.E.

(e) Address 1434 Duval St. S.E.

(f) Address 1434 Duval St. S.E.

(g) Address 1434 Duval St. S.E.

(h) Address 1434 Duval St. S.E.

(i) Address 1434 Duval St. S.E.

(j) Address 1434 Duval St. S.E.

(k) Address 1434 Duval St. S.E.

(l) Address 1434 Duval St. S.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-1943 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5-1943 to 9-8-1943, and that I last saw her alive on 9-8-1943.

Immediate cause of death

Cerebral hemorrhage

Duration

4 days

Due to Hypertension + arteriosclerosis 4 years

Due to

Other Condition Previous hemorrhages

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank A. Saunders

Address 1029 N. Street S.E. Date signed 9-10-43

M. D.

SEP 13 1943

G 08085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08085

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Harford

(c) City or town: Darlington

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 13 1943

VB 156

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1943 to 9/12 1943, and that I last saw him alive on 9/12 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed 9/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

08086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08086

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **3008 Benson Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **16 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3008 Benson Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Auguste A. Schmidt**

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Herman Schmidt**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Aug. 26, 1871.**

8. AGE **72** Years Months **15** Days If less than one day hr. min.

9. Birthplace **Germany**
(Town, county, and state)

10. Usual Occupation **H.W.**

11. Industry or business

12. Name **Wm. Sienkus**

13. Birthplace **Germany**

14. Maiden Name **Unknown**

15. Birthplace **Germany**

16 (a) Informant **Mr. Herman Schmidt**

(b) Address **3008 Benson Ave.**

17 (a) **Burial** (b) Date thereof **Sept. 13/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **New Cathedral**

Location **4300 Old Frederick Rd.**

18 (a) Funeral director **Harry H. Witzke**

(b) Address **4101 Edmondson Ave.**

19. Registrar **Huntington Williams, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 11 1943 at 10 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 1 1943** to **Sept 11 1943** and that I last saw him **live on Sept 10 1943**

Immediate cause of death

General Metastasis from Carcinoma Ovary
Due to **Carcinoma Ovary**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury **Thomas S. Benson**

23. Signature **Mid Auto Bldg** M. D.

Address **Sept 12-43**

G 08087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08087

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name of father

13. Birthplace

14. Maiden Name of mother

15. Birthplace

16 (a) Informant

16 (b) Address

17 (a) Burial (Burial, cremation, or removal)

17 (b) Date thereof (Month) (day) (year)

17 (c) Cemetery or crematory

17 (d) Location

18 (a) Funeral director

18 (b) Address

19 (a) Date of death

19 (b) Signature of physician

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the cause of death clearly and legibly.

SEP 13 1943

VS 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

08089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G-08089

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3902 Main Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

GRACE BIXBEE HORNADAY

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex
female

5. Color or race
white

6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife Calvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1876

8. AGE: Years 67 Months 5 Days 20
If less than one day
hr. min.

9. Birthplace Keokuk, Iowa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John M. Bixbee

13. Birthplace Cumington, Mass.

14. Maiden Name Abigail Tyler

15. Birthplace New York

16 (a) Informant Mrs. Nellie Wright

(b) Address 3902 Maine Ave.

17 (a) Burial (b) Date thereof 9/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 19 43 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 14 1942 to Sept. 9 1943.
and that I last saw her alive on Sept. 9 1943.

Immediate cause of death.

Coronary Occlusion
Due to Coronary arteriosclerosis

Due to generalized
arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Carter Edel
Address 3403 Fernside Blvd Date signed 9/15/43

Duration
Sudden

?

?

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08090

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Girl Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1943

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace Balto.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Harry Kaplan

13. Birthplace N. Y. City

MOTHER

14. Maiden Name Rhea Pavick

15. Birthplace Pa.

16 (a) Informant Mr. Harry Kaplan

(b) Address 1905 Bloomingdale Rd.

17 (a) Burial (b) Date thereof 9/13/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

SEP 13 1943

(Date rec'd by) Washington Williams, M.D., Registrar

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limit, give RURAL and give town)

(d) Street No. 1905

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

(BARBARA ANN KAPLAN)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1943 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943 to 9/11 1943 and that I last saw her alive on 9/11 1943

Immediate cause of death

Dysentery - Malignant Pharyngeal Cancer

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Cohen

Address University Hosp. Date signed 9/14/43

Duration

1 month

PHYSICIAN

Underline the cause to which death should be charged statistically.

08091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08091

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 700 W. 40th St.

(c) Hospital or institution:

Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 9 13

(e) Length of stay in Baltimore (yrs., mos., or days) 66 7 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Blanche Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1977

8. AGE: Years Months Days If less than one day
66 7 2 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

artist

11. Industry or business

12. Name Livingston Orrick Bennett

13. Birthplace Baltimore, Md.

14. Maiden Name Cornelia Wally Hershey

15. Birthplace Illinois

16 (a) Informant Home for Incurable Records

(b) Address 700 W. 40th St.

17 (a) BURIAL (b) Date thereof 7/13/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western

Location BALTIMORE

18 (a) Funeral director W. J. Tuckner & Sons

(b) Address North Penn. Ave. Balt. Md.

SEP 13 1943

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1943, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12, 1938, to Sept. 11, 1943, and that I last saw her alive on Sept. 9, 1943.

Immediate cause of death

Acute Myocardial Infarction

Duration 3 days

Due to Hypertensive Cardiac-Vascular Disease

Many years

Due to

Other Conditions Carcinoma of Breast with widespread metastases
(Include pregnancy within 9 months of death)

7 years

Date of operation

Major findings of operations

PHYSICIAN
Underline the cause to which death should be charged statistically.

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas Cornelia Wally

Address 11 E. Chase St. Date signed 9/11/43

G 08092

Evelyn Swann
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08092
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

556 Bloom St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

7

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 23, 1922

8. AGE:

Years

Months

Days

If less than one day

21

4

17

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Mack Swann

13. Birthplace

md

14. Maiden Name

Ardenus Roberts

15. Birthplace

md

16 (a) Informant

Ardenus Swann

(b) Address

556 Bloom St

17 (a)

Burial

(b) Date thereof

9-13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

mt Zion Am.

Location

18 (a) Funeral director

George H. Nelson

(b) Address

1343 Priestman St

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Balto md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

556 Bloom St

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/10

9/10

M

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

B. M. Swann

M. D.

Address

39

Date signed

SEP 13 1943

G 08093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08093

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw her alive on

Immediate cause of death

Hypertensive-Cardio-renal disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P 137943

G 08094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08094

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed

FINGERPRINTS PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 13 1943

G 08095

BALTIMORE CITY HEALTH DEPARTMENT

G 08095

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

47

48

11

28

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1943 to 9/12 1943, and that I last saw her alive on 9/12 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

Four minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

P 19 1943

VS 150

Correct age is especially important. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 08096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08096

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 813

Frederick Ave

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

BERNARD

E

SELBY

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-07-2124

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Anna Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 19 1894

8. AGE:

Years

Months

Days

If less than one day

58

7

22

hr.

min.

9. Birthplace

Baltimore Md

(City, county, and state)

10. Usual Occupation

Painter

11. Industry or business

Do it 11/17

FATHER

12. Name

Ellsworth Selby

13. Birthplace

England

MOTHER

14. Maiden Name

Richard Smithson

15. Birthplace

Maryland

16 (a) Interment

Wm A M Selby

(b) Address

813 Frederick Ave

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

8-14-43

(c) Cemetery or crematory

Loudon Park

Location

Baltimore Md

18 (a) Funeral director

Wm A M Selby

(b) Address

Catonville Md

19 (a)

(Date rec'd by registrar)

Sept 13 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1943 at 7 PM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wallenwater M.D.

Date signed 9-11-43

G 08097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08097

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Archer street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Kenneth Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

September 20, 1944

8. AGE:

Years

Months

Days

If less than one day

1

2

11

20

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name Richard Jackson

13. Birthplace

Cynthiana

MOTHER

14. Maiden Name Lois Stevens

15. Birthplace Baltimore Maryland

16 (a) Informant

Lois Stevens

(b) Address

624 Archer street

17 (a)

Burial

(b) Date thereof

Sept 18, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mount Auburn

Location

Baltimore City

18 (a) Funeral director

Joseph G. Birch

18 (b) Address

1000 Mount Street

18 (c) Date rec'd by registrar

Sept 13, 1943

18 (d) Signature

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/10

1943

at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1943 to 9/10 1943 and that I last saw him alive on 9/10 1943.

Immediate cause of death

acute glomerulo-nephritis

Due to

Septic sore throat

Due to

(Pharyngitis)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. Oden

Address University Hospital

Date signed

M.D.

9/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08098

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2217 Wilkens Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **20**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2217 Wilkens Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Carrie M. Farrar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W.6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife

Late Frank H. Farrar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 9, 1871.**

8. AGE: Years **71** Months **10** Days **1** If less than one day
hr. min.

9. Birthplace **Balto. Md.**

(Town, county, and state)

10. Usual Occupation

H.W.

11. Industry or business

FATHER
MOTHER

12. Name

Kollitsch

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany16 (a) Informant **Mrs. Myrtle Scherer**(b) Address **2217 Wilkens Ave.**

17 (a) Burial

(b) Date thereof **Sept. 14/43.**
(month) (day) (year)(c) Cemetery or crematory **Loudon Park**Location **3801 Frederick Rd.**

18 (a) Funeral director

Harry H. Kutzke(b) Address **4101 Edmondson Ave.****SEP 13 1943**(b) Registrar **William H. Williams**

VB 154

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/10** 19 **43** **7 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **6/1** 19 **43** to **9/10** 19 **43** and that I last saw her alive on **9/10** 19 **43**

Immediate cause of death **Arterio-sclerotic cardiac vascular disease**

Due to

Due to

Other Conditions **Cerebral thrombosis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature **Benjamin Miller**

M. D.

Address **2030 Wilkens Ave.**Date signed **9/13/43**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.08100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

808100
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 1 month of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

008102

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

008101

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4220 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lessie Feinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry S Feinberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 25, 1893

8. AGE: Years 49 Months 9 Days 17
If less than one day hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

12. Name Emanuel E. Mendelsohn

13. Birthplace Russia

14. Maiden Name Sarah Rose Simon

15. Birthplace Russia

16 (a) Informant Harry S. Feinberg

(b) Address 4220 Park Heights Ave

17 (a) Burial (b) Date thereof Sept, 14, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1943, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1943 to Sept 12 1943 and that I last saw him alive on Sept 12 1943

Immediate cause of death

3 Acute Cerebral Hemorrhage

Duration

Due to

Due to

Other Conditions Ch Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. L. Hornstein

M. D.

Address 733 Annapolis St Date signed 9/13/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8.08103
~~6-08103~~

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 808103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6008 Wallis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6008 Wallis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Silverstein

3 (b) If veteran, name war 3 (c) Social Security Account No. 182-01-6842

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sadie 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1897

8. AGE: Years 46 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant Grocer

12. Name Jacob Silverstein

13. Birthplace Russia

14. Maiden Name Pearl ?

15. Birthplace Russia

16 (a) Informant Mrs Sadie Silverstein

(b) Address 6008 Wallis Ave

17 (a) Burial (b) Date thereof Sept 13, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Philadelphia Penna
Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 8.30
20. DATE OF DEATH Sept 13, 1943 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1943 to Sept 13 1943, and that I last saw him alive on Sept 13, 1943.

Immediate cause of death

Cerebral Apoplexy
Due to hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Schenker

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Address 1919 E. North Ave Date signed 9/13/43

Schenker

G 08104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08104

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town 1301 Timore.
(If outside city or town limits, write RURAL and give town)(d) Street No. 1704 Moreland Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Anna Lind

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced

married

6 (b) Name of husband or wife

Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 1 1890

8. AGE: Years

Months

Days

If less than one day

M.

52

10

11

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House work

FATHER
MOTHER

12. Name

Kapel Berlin

13. Birthplace

Russia

14. Maiden Name

Kha Udelsky

15. Birthplace

Russia

16 (a) Informant

Harry Lind

(b) Address

1704 Moreland Ave

17 (a)

(b) Date thereof

Sept 14/43

(c) Cemetery or crematory

Bnai Israel

Location

Southern Ave

18 (a) Funeral director

Sol Gervin Bros

(b) Address

124-26 W North Ave

SEP 13 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/12 1943 at 7:04 P M

21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Hugh B. McHally, M.D.

Date signed

9/13/43

Medical Examiner.

G 08105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08105

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 20, 1943, to Sept. 10, 1943, and that I last saw him alive on Sept. 9, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Date signed

G 08106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08106

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *D.O.A.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *642* *Avon St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 19, 1892*

8. AGE:

Years

Months

Days

If less than one day

*50**5**22*

hr.

min.

9. Birthplace *Jerry Mill Lane Ball Co. Md.*

(Town, county, and state)

10. Usual Occupation

H. housewife

11. Industry or business

FATHER
MOTHER12. Name *Thomas Matthews*

13. Birthplace

*md.*14. Maiden Name *Mary Johnson*

15. Birthplace

*md.*16 (a) Informant *Walter Matthews*(b) Address *642 Avon St.*17 (a) *Burial* (b) Date thereof *Sept. 15/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Int. Calvary Cem*
Location *G. G. Cochrane*18 (a) Funeral director *Mrs. R. D. Elliott & Dgt*(b) Address *129 N. Calver St.*

SEP 13 1943

(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 4* 1943, at *1* A M21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *her* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH *Chronic*
myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature *Robert Lee Graham* M.D.

Medical Examiner.

Date signed *Sept. 11* 1943

G 08107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08107

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

STANLEY KIDD

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife

Olivia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 7, 1885

8. AGE:

Years

Months

Days

If less than one day

58

7

3

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Harrison Kidd

13. Birthplace

Va.

14. Maiden Name

Priscilla Banks

15. Birthplace

Va.

16 (a) Informant

Olivia Kidd

(b) Address

1023 N. Wolfe St

17 (a)

Burial

(b) Date thereof

Sept 15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Int. Calvary Cem

Location

A.A. County

18 (a) Funeral director

Mrs R. G. Elliott & Son

(b) Address

1129 N. Caroline St

EP 13-1943

(b) Registrar

Huntington Williams

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1023 N. Wolfe Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1943, at 5:35 A.M.

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in myopinion resulted from: natural causes ☒, accident ☐, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature J. W. Allen M.D.

Medical Examiner.

Date signed 9-10-43

G 08108

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08108

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 423 St. Mosher St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Maria C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 20, 1921

8. AGE: Years

Months

Days

If less than one day

22

4

1020

hr.

min.

9. Birthplace

Lawrence, S.C.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Robert B. Phillips

13. Birthplace

Marion, S.C.

14. Maiden Name

Hattie Kershaw

15. Birthplace

Sumter, S.C.

16 (a) Informant

Hattie Phillips

(b) Address

423 St. Mosher St.

17 (a)

Burial

(b) Date thereof

Sept 1943

(c) Cemetery or crematory

Sumter, S.C.

Location

Sumter, S.C.

18 (a) Funeral director

George J. Holland

(b) Address

291 Dupont Hill Ave.

(c) Date of funeral

Sept 13, 1943

23. Signature

James D. Carr

Address

515 Mather St

Date signed

9/17/43

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town

Baltimore

(d) Street No.

423 St. Mosher St.

(e) Citizen of foreign country?

(If rural give location)

(f) If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 10, 1943, at 4:18 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 2 1943, to Sept 10 1943.

and that I last saw him alive on Sept 10 1943.

Immediate cause of death

pulmonary edema

Due to sub-acute bacterial

endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

9/17/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08109

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town

(d) Street No. 1309 Wesley Alley

(e) Citizen of foreign country

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1943, to 9/12 1943, and that I last saw him alive on 9/12 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/13

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

SEP 13 1943

G 08110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08110

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2844 Harford Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2844 Harford Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Howard Carrollton Shaven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Daisy Shaven

6 (c) If alive, give age

84 years

7. Birth date of deceased (mo., day, yr.)

July 7, 1877

8. AGE:

Years

Months

Days

If less than one day

65

66

2

5

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

Bung Rd.

12. Name

Daniel M. Shaven

13. Birthplace

MD

14. Maiden Name

Josephine Coonell

15. Birthplace

MD

16 (a) Informant

Mrs Daisy Shaven

(b) Address

2844 Harford Rd

17 (a)

Burial

(b) Date thereof

Sep 15, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood Cem

Location

Rural

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2804 S. Orleans St

1943

(b)

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12, 1943, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended

deceased from 9-9-1943, to 9-12-1943.

and that I last saw him alive on 9-11-1943.

Immediate cause of death

Coronary disease

(occlusion)

Due to

Arteriosclerosis

Duration

12 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. D. Sybert

Address

2802 Harford Rd

Date signed

9-13-43

G 08111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08111

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1528 Park Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY C DEMBOSKI

3 (b) If veteran, name war

N

3 (c) Social Security Account

No. N/A

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1918

8. AGE: Years 25 Months 6 Days 15 min.

9. Birthplace Masthope NJ
(town, county, and state)10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph L Johnson13. Birthplace Mahomed14. Maiden Name Mary M Monington15. Birthplace Mahomed16 (a) Informant Thomas Demboski(b) Address 1526 Park Ave17 (a) burial (b) Date thereof 9/15/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St JosephLocation St Joseph18 (a) Funeral director William C. Inc(b) Address 1217 St Paul St19 SEP 13 1943 (b) Thomas Demboski

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11, 1943 at 1:10 PM21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of cervical vertebraeDue to accidental fall

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9-11-43 at 1:10 P. 14/1(b) Where did injury occur? home address(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? -(d) Means of injury fall from high place23. Signature H. J. Wollanover MD
Assistant Medical ExaminerDate signed 9-12-43 while hanging out
clothes

G 08112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08112

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital 81

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1610 LLEWELLYN AVE.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. Joseph W. Wooden

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 220 07 9572

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife LILLIAN M. WOODEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 22 1898

8. AGE: Years Months Days If less than one day

45

0

21

hr.

min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation ELEVATOR OPR.

11. Industry or business GLEN L. MARTIN

12. Name THOMAS C. WOODEN

13. Birthplace BALTO. MD.

14. Maiden Name LOUISE HARRMAN

15. Birthplace BALTO. MD.

16 (a) Informant LILLIAN M. WOODEN (WIFE)

(b) Address 1610 LLEWELLYN AVE.

17 (a) BURIAL (b) Date thereof SEPT. 15/45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory BALTIMORE

Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly and Geisler INC.

(b) Address 403 S. MOORE ST.

SEP 13 1943 (a) Date rec'd by registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12, 1943, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4, 1943, Sept. 12, 1943, and that I last saw him alive on Sept. 12, 1943.

Immediate cause of death

Congestive Heart Failure

Duration

Due to Hypertensive Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Frusting M.D.
Address St. Joseph's Hosp. Date signed 7-12-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08113

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

M

5. Color of race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

Georgia Davenport

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant GEORGIA DAVENPORT (WIFE)

(b) Address CRISFIELD MD.

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof SEPT. 15/43

(month) (day) (year)

(c) Cemetery or crematory CRISFIELD CEM.

Location CRISFIELD MD.

18 (a) Funeral director John J. Bradshaw

(b) Address CRISFIELD MD.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Somerset

(c) City or town

Crisfield

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12

4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1943 to 9-12 1943

and that I last saw him alive on 7-11-43 19

Immediate cause of death

Uremia

Due to

Chronic Nephritis

Due to

Other Conditions

Latent Syphilis, Diabetes Mellitus, Hypertension, and Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

No

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ralph L. Chenoweth

Address

University Hospital

Date signed 9/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sr. 901 Aisquith Street
(c) Hospital or institution:
Motherhouse of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) City (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Sr. M. Geargette Nueslein
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1890
8. AGE: Years Months Days If less than one day
53 7 22 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

12. Name Joseph Nueslein

13. Birthplace Germany

14. Maiden Name Wilhelmina Weinkamp

15. Birthplace Baltimore

16 (a) Informant Sr. M. Stan. Kostka

(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof Sept. 14th 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Notch Cliff, Private
Location Glen Arm. Md.

18 (a) Funeral director Geo. M. Bink & Son.

(b) Address

SEP 14 1943 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1943 at 8.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1943 to Sept. 12 1943 and that I last saw her alive on Sept. 10 1943

Immediate cause of death

Carcinoma
Due to pleura
Due to Metastases
Other Conditions Alcohol

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: ✓

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ✓

(b) Date of occurrence ✓ at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury ✓

23. Signature J. Bink

Address 1106 North Ave signed 9/13/43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

08115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08115
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 33rd & Calvert
 (c) Hospital or institution: Union Memorial Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2
 (e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County Hartford
 (c) City or town Aberdeen, R.F.D.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____ (If rural give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

Mr. Robert Rogers Casilly
 3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Vera Marie Casilly
 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 6, 1899

8. AGE: Years 64 Months 3 Days 75 If less than one day _____ hr. _____ min.

9. Birthplace Ohio
 (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business _____

12. Name Thomas A. Casilly

13. Birthplace Ohio

14. Maiden Name O'Leary Dietrich

15. Birthplace Ohio

16 (a) Informant wife

(b) Address Aberdeen Maryland R.F.D.

17 (a) Burial (b) Date thereof Sept. 14, 1943
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Francis
 Location Aberdeen, Hartford Co.

18 (a) Funeral director Howard K. McCombs & Son

Address Aberdeen, Md.

SEP 14 1943 (Date rec'd by registrar) William M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1943, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1943, to Sept. 11 1943, and that I last saw him alive on Sept. 11 1943.

Immediate cause of death Parotitis & gastric hemorrhage Duration 1-2 days

Due to Perforated duodenal ulcer 1 day

Due to _____

Other Conditions A second duodenal ulcer & bleeding

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operations _____

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M.

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signatures John A. Marshall Jr. M. D.

Address Union Memorial Hosp. Date signed Sept 14 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

88116

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08116
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

20

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 9-6-1943 to 9-12-1943.

and that I last saw him alive on 9-11-1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed

SEP 14 1943

Registrar

VS 1

9-13-43

G 08117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08117

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4724 Park Heights Ave.
- (c) Hospital or institution:
Baltimore, Md.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 4724 Park Heights Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Katharine J. Wilmering

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1879

8. AGE: Years 63 Months 10 Days 5 If less than one day
hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Housework11. Industry or business At home12. Name Frank Wilmering13. Birthplace Germany14. Maiden Name Anna Tuschen15. Birthplace Germany16 (a) Informant Amelia Wilmering(b) Address 4724 Park Heights Ave.17 (a) Burial (b) Date thereof 9-14-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer
Location Baltimore City18 (a) Funeral director G. Vernon LemmerAddress 4611 Park Heights Ave.19 SEP 14 1943
(Date rec'd by registrar) Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1943, 10:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1943 to Sept. 11 1943 and that I last saw him alive on Sept. 11 1943.

Immediate cause of death

Chronic Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify exact place) While at work?

(e) Means of injury

23. Signature Thurston WilliamsAddress 4803 Park Hgts. Ave. Date signed _____

Duration

7

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08118
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 55th & Calvert St.
- (c) Hospital or institution:
Union Memorial Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 10
- (e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:

- (a) State N.C. (b) County
- (c) City or town Newbern N.C.
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 509 Spencer Ave.
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MR. JOSEPH ORRINGER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife MRS. ANN ORRINGER

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MARCH 18, 1886

8. AGE:

Years

Months

Days

If less than one day

68525

hr.

min.

9. Birthplace

AUSTRIA

(Town, county, and state)

10. Usual Occupation

Pickle magnifier

11. Industry or business

snuff.

FATHER

12. Name

AARON ORRINGER

13. Birthplace

AUSTRIA

MOTHER

14. Maiden Name

HANNAH ?

15. Birthplace

AUSTRIA

16 (a) Informant

Mrs. ANN ORRINGER

(b) Address

509 Spencer Ave. Newbern

17 (a)

Removal

(b) Date thereof

9-14-43

(c) Cemetery or crematory

Lithburg, Pa

Location

Joe Reina Inc

18 (a) Funeral director

1439 E. Baltimore St

(b) Address

Huntington Williams

19

SEP 14 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1943 at 8:45 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1943, to Sept 13 1943, and that I last saw him alive on Sept. 13 1943.

Immediate cause of death

Cardio. Resp. failureDue to Edema of brain
Rt. temporal lobe

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept. 11Major findings of operations: Brain tumorEdema of Rt. temporal lobe

of autopsy.

Duration

4-5 PM

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____ (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature James M. McCall Jr.Address Union Memorial Hospital Date signed 9-13-43

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08119

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Park Heights Ave
(c) Hospital or institution: St Louis Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Paulk
(c) City or town Paulk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

129 TINKEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890
8. AGE: Years 53 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Nathan Fishbein
13. Birthplace Russia
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 9-14-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Louis Home
Location Park Heights Ave

18 (a) Funeral director Paulk Sons Inc
(b) Address 1439 E. Paulk St

19 SEP 14 1943
(Date rec'd by registrar) Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1943, at 6:25 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Sept 13 1943, and that I last saw her alive on Sept 13 1943.

Immediate cause of death
Cancer of lung with metastases to brain
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norton E Lowman M. D.
Address 5013 Park Heights Ave Date signed 9-13-43

Duration

Jan 1, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

08120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08120

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1718 McCulloch St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Joseph Butler

13. Birthplace

Dorchester Md.

14. Maiden Name

Flora Johnson

15. Birthplace

Dorchester Md.

16 (a) Informant

Flora Johnson

(b) Address

1718 McCulloch St.

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 10 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 12 1943

(Date rec'd by registrar)

Huntington Williams, M.D. Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

1718 McCulloch St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 11 1943

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1943 to Sept 11 1943.

and that I last saw him alive on Sept 11 1943.

Immediate cause of death

Malnutrition

Duration

2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Sep 11 1943

M. D.

Address 632 Daniel Hall Ave signed

VS 2

0354

9-11-43

G 08121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08121

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hr. 30 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 9 hr. - 30 min.

3 (a) FULL NAME

Donna Jacqueline Gue

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13-1943

8. AGE:

Years

Months

Days

If less than one day

9 hr. 30 min.

9. Birthplace Bon Secours Hospital

(Town, county, and state)

10. Usual Occupation

Infant.

11. Industry or business

FATHER

12. Name Carl Edgar Gue

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Audrey Marie Jenkins

15. Birthplace Baltimore Md.

16 (a) Informant Bon Secours Hosp.

(b) Address 2025 W Fayette St.

17 (a) Burial (b) Date thereof Sept. 14-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Balto. Md

18 (a) Funeral director Geo. L. Bay Jr.

(b) Address 512 Volturn St.

SEP 14 1943 (c) (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 840 Whitmore Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13-1943 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-1943 to 8-13-1943 and that I last saw her alive on 8-13-1943.

Immediate cause of death

Congenital Atresia

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard S. Rude

M. D.

Address Bon Secours Hosp. Date signed 9/14/43

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

08122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 94W

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-12-1908

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1887

8. AGE: Years 53- Months 10 Days 8 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Railroad Engineer

11. Industry or business B & O R.R.

12. Name William High,

13. Birthplace Baltimore Md.

14. Maiden Name Georgianna Brown,

15. Birthplace Baltimore Md

16 (a) Informant Mrs Ann Rebecca High,

(b) Address 610 Ashburton St

17 (a) Burial (b) Date thereof Sept. 15, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director George W. Little,

(b) Address 2700 Edmondson Ave.

19 (a) SEP 14 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 610 Ashburton St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13, 1943, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to Sept 13, 1943, and that I last saw him alive on Sept 13, 1943.

Immediate cause of death

Coronary artery disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. W. Wallenstein M.D.

Address 2047 Eutaw Pl. Date signed Sept 13/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08123
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

DoA South Baltimore Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 124 Scott St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Adreon

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Emma Adreon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) June 15, 1876

8. AGE:

Years

Months

Days

If less than one day

67

2

27

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Unemployed

FATHER
MOTHER

12. Name John Adreon

13. Birthplace

Md.

14. Maiden Name Ellen Jane Holland

15. Birthplace

Md.

16 (a) Informant Walter Adreon

(b) Address 1036 Patapiscus St.

17 (a)

Burial

(b) Date thereof

9/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a)

SEP 14 1943

(b)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/12

1943, at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arterio-sclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. McNeally M.D.

Date signed

9/13/43

Medical Examiner.

G 08124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1741 E Pratt St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

*ALBERT**MARTINI*

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. *None*

4. Sex

m

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *Sept 3rd 1871*

8. AGE:

Years

Months

Days

If less than one day

*72**0**8*

hr.

min.

9. Birthplace:

Balto Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

at Large

FATHER

12. Name

Albert Martini

13. Birthplace

Germany

MOTHER

14. Maiden Name

Elizabeth Jimmarina

15. Birthplace

Balto Md.

16 (a) Informant

Miss Elsie Worrall

(b) Address

3920 Kimble Rd

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

9/14/43
(month) (day) (year)

(c) Cemetery

St. Casimir

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. Paul St.

19 (a)

SEP 14 1943
(Date of registration)

(b)

Huntington, William, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 11 1943 at 5³⁰ M*

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carbon monoxide poisoning

Due to

suicide

Other Conditions

no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury *9-8-43 at 5:05 P. M.*(b) Where did injury occur? *1741 E Pratt St*(c) Did injury occur at home, on farm, industrial place, in public place? *home* While at work?(d) Means of injury *illuminating gas*

23. Signature

W J Wollamacher M.D.

Signed

9-12-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The every item of information should be carefully supplied.

G 08125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d G 08125
Registered No.

JL - 83730

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1119 Gorsuch Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Adelaide Norton

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. DHE

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1876

8. AGE: Years Months Days If less than one day

67

5

6

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

Self

12. Name George Pryor

13. Birthplace Md.

14. Maiden Name Liss Bell

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/14/43

(Burial, cremation, or reinterment)

(month) (day) (year)

(c) Cemetery or crematory

Landon Park

Location

Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address

1217 St. Paul St

19 (a) (b)

(Date rec'd by registrar)

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1943 at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1943 to 9-10 1943, and that I last saw her alive on 9-10 1943.

Immediate cause of death

Cardiac failure

Duration

4 hrs

Due to Hypertension and atherosclerosis

with last disease

Diagnosed with arrhythmia

fibrillation

?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Paul Hett

Address RCH

Date signed 9/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 14 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

AB-83762G 08126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 08126
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 W. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry Compton

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1894

8. AGE: Years Months Days If less than one day

49

?

7

?

16

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name James W. Compton

13. Birthplace Md.

MOTHER

14. Maiden Name Katie Stall

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address

Records

17 (a) Burial (b) Date thereof Sept 15/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location

Hampden
Chenoweth & Donovan

18 (a) Funeral director

(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 14 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/12 1943 at 3:35 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/11 1943 to 9/12 1943
and that I last saw him alive on 9/12 1943

Immediate cause of death

Coronary - vascular
collapse

Due to Unknown - med.
examiner's case

Due to

Other Conditions

acute alcohol-
ism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

M. E. Case

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. J. Serjman

BCH

Date signed 9/13

Duration

16 hr.

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

For S.H.K. Hollenbecker, from H.J. Malpass

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

938

G 08127

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 518 S. HIGHLAND AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. HIGHLAND AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

TERESIA FISCHER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife MICHAEL FISCHER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

NOV. 15 1874

8. AGE:

Years

Months

Days

If less than one day

85

7

9

28

hr.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual Occupation

HOUSE WIFE

11. Industry or business

AT HOME

FATHER
MOTHER

12. Name

?

DORBERT

13. Birthplace

GERMANY

14. Maiden Name

UNKNOWN

15. Birthplace

GERMANY

16 (a) Informant MARY FISCHER (DAUGHTER)

(b) Address

518 S. HIGHLAND AVE.

17 (a)

BURIAL

(Burial, cremation, or removal)

(b) Date thereof SEPT. 16/43

(month) (day) (year)

(c) Cemetery or crematory

HOLY REDEEMER

Location

BELAIR ROAD

18 (a) Funeral director

Lilly and Zeiler INC.

(b) Address

403 S. WOLFE ST.

SEP 14 1943

VS 180

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH SEPT. 13 19 43 at 12/10

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1943 to Sept 13 1943 and that I last saw h. h. alive on Sept 13 1943.

Immediate cause of death

Myocardial infarction

Duration

1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Adam J. Blechman

Address

35 W. Dora

Date signed

M. D.

Adam Blechman Sept 13/43

The correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

930

G 08128
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 432 S. ROBINSON ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 432 S. ROBINSON ST.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

AUGUST POHLNER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 205-05-9267

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife AGNES POHLNER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 3 1888

8. AGE: Years Months Days

If less than one day

55

5

10

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation LADIES DRESS CUTTER

11. Industry or business THE GOLDMAN CO.

FATHER
MOTHER

12. Name ADOLF POHLNER

13. Birthplace GERMANY

14. Maiden Name MARY WIESSNER

15. Birthplace GERMANY

16 (a) Informant CARL L. POHLNER (SON)

(b) Address 432 S. ROBINSON ST.

17 (a) BURIAL

(b) Date thereof SEPT. 16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler, N.C.

(b) Address 403 S. WOLFE ST.

19 (a)

SEP 17 1943

(b) Registrar

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH SEPT. 13 1943 at 3/15M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1943 to Sept 13 1943, and that I last saw him alive on Sept 13 1943.

Immediate cause of death

Myocardial Infarction
Cholesterolosis

Duration

1932

Due to

Cerebral Hemorrhage Sept 6 1943

1943

Due to

Myocardial Infarction

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Blackman Sept 13-43

44034408129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08129
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

CARL HELLAND

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

DIVORCED

6 (b) Name of husband or wife

OLIVE G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-24-91

8. AGE:

Years

Months

Days

If less than one day

52

1

18

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

BANKING -

11. Industry or business

BRANCH MGR. FIDELITY TRUST

FATHER
MOTHER

12. Name

HENRY HELLAND

13. Birthplace

Md

14. Maiden Name

MARY SCHAUB

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

9/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cem.

Location

Baltimore, Md.

18 (a) Funeral director

W. J. TICKNER & SONS

(b) Address

Baltimore, Md.

19 (a)

(b)

SEP 14 1943

Huntington Hall, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4665 Park Heights Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12 1943 at 9:00 P

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug 28 1943 to Sept 12 1943.

and that I last saw him alive on Sept 12 1943.

Immediate cause of death

Pulmonary Embolism?

Duration

Due to

thrombosis of intra abdominal
vein?

Due to

Perforated sigmoid
ruptured appendix.

Other Conditions

Cerebral thrombosis

Fecal fistula

(Include pregnancy within 3 months of death)

Date of operation

Aug 28 - 1943

Major findings of operation:

Ruptured

appendix & abscess

of autopsy

adhesion none here

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles Stenon Welch

Address

Johns Hopkins Hospital signed 9-12-43

G 08130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G 08130

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3100 N. + Wyman Pk Drive

(c) Hospital or institution:

U.S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour 3 min

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County

(c) City or town Germantown

(If outside city or town limits, write RURAL and give town)

(d) Street No. 61 W. School Lane

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Edwin D. Morrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-3-1907

8. AGE:

Years

Months

Days

If less than one day

36

1

10

hr.

min.

9. Birthplace

Philadelphia Pennsylvania

(Town, county, and state)

10. Usual Occupation

Yeoman

11. Industry or business

United States Navy

FATHER

12. Name

Unknown James Morrison

13. Birthplace

R. W. 2nd Ave

MOTHER

14. Maiden Name

Mary Duncan

15. Birthplace

Unknown

16 (a) Informant

Records

(b) Address

U.S. Marine Hospital

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9/14/43

(month) (day) (year)

(c) Cemetery or crematory

?

Location

Philadelphia, Pa.

18 (a) Funeral director

H. W. Moore & Son

(b) Address

805 W. Calvert St.

19 (a)

(Date rec'd by registrar)

H. W. Moore & Son

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1943, at 4:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13-43 19 to 9-13-43 19.

and that I last saw him alive on 9-13-43 19.

Immediate cause of death

Laceration of Brain

Due to

Gunshot wound

Due to

Other Conditions

Fracture, comminuted, of skull

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Suicide

(b) Date of occurrence

9-13-43, 2 P.M.

(c) Where did injury occur?

Baltimore Md.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

Gunshot

23. Signature

L. W. Moore

M. D.

Address 45 Marine Hospital

Date signed 9-13-43

Duration

2 Hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

SEP 14 1943

G 08131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08131

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles P. Marguard

3 (b) If veteran, name war

3 (c) Social Security Account

No.

None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband

Christina Marguard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 31, 1863

8. AGE:

Years

Months

Days

If less than one day

79

8

13

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

Marguard

13. Birthplace

Germany

14. Maiden Name

Halkowen

15. Birthplace

Germany

16 (a) Informant

Mrs. Dorothy Phipps

(b) Address

139 N. Ellwood Ave.

17 (a)

Burial

(b) Date thereof

Sept. 16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Matthews Cem.

Location

Baltimore, Md.

18 (a) Funeral director

Philip's Funeral Home

(b) Address

2024 Orleans St.

19 (a)

SEP 14 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

139 N. Ellwood Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-13-1943, at 2:30 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions

Multiple abrasions,

contusions & laceration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-12-43 at 6 P. M.

(b) Where did injury occur? East Ave. & Fayette St.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work? No

(d) Means of injury Pallet man, struck by tractor-trailer

23. Signature

Howard J. Wallace

M.D.

Date signed 9-13-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08132
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2027 Portugal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Portugal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Martin Juras
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

12. Name John Kuras

13. Birthplace Poland

14. Maiden Name Zofia

15. Birthplace Poland

16 (a) Informant John Kuras

(b) Address 2027 Portugal St.

17 (a) Burial (b) Date thereof Sept. 15/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski

(b) Address 1930 Eastern Ave.

19 (a) (b) Registrar
(Date received by registrar)

SEP 14 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1943 at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1943 to 9/12 1943, and that I last saw him alive on Sept 12 1943

Immediate cause of death
CORONARY OCCLUSION

Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE 8 YEARS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Joseph F. Hoenig
Address 2098 Chester St Date signed 9/13/43

Duration
9/12/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08133

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Hauke Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary M. Furman Foster

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1902

8. AGE: Years Months Days If less than one day

41 hr. min.

9. Birthplace

Chicago

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

12. Name

Pete Mikas

13. Birthplace

Poland

14. Maiden Name

?

15. Birthplace

Poland

16 (a) Informant

Michael Furman

(b) Address

1108 Hauke St.

17 (a) Burial

Burial

(b) Date thereof

Sept 16/43

(c) Cemetery or crematory

Holy Cross Alico

Location

Baltimore

18 (a) Funeral director

David W. Ozgurki

(b) Address

1938 Eastern Ave.

19 (a) SEP 14 1943

(b) Registrar

Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13-43 1943 at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1943 to 9-13 1943, and that I last saw her alive on 9-13 1943.

Immediate cause of death
Fractured skull

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 9-12-43 at 12:00 M

(c) Where did injury occur? Baltimore, Md.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? 5. street While at work? No

(Specify type of place)

(e) Means of injury Fall

23. Signature Charles Maynard

Address 1213 Light St Date signed 9-13-43

M. D.

Approved by Howard J. Wallace, M.D.

G 08134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8G 08134

Registered No.

83743

T.N

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 730 S. Broadway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Harry Holcomb

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Florence (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1875

8. AGE: Years Months Days If less than one day

67

8

8

hr.

min.

9. Birthplace Kansas

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Robert Holcomb

13. Birthplace Ill.

14. Maiden Name Jennie Coffield

15. Birthplace Kansas

16 (a) Informant 4940 Eastern Ave

(b) Address Baltimore City Hospitals

17 (a) Burial (b) Date thereof Sept 15/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral Director Fred W. O'Connell

(b) Address 1930 Eastern Ave

19 SEP 14 1948

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/13 1948 2:20 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/10 1948 to 9/13 1948.

and that I last saw him alive on 9/13 1948.

Immediate cause of death Pneumonia

X. upper & lower lobes

Duration

1 wk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

As above & multiple
of autopsy: small abscess of lung

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Seigman

Address

BCH

Date signed

9/13

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08135

Registered No.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12/43 to 9/13/43, and that I last saw him alive on 9/13/43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 14 1943

correct are especially important. Physicians: please

G 08136
Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) State PA (b) County PA

(a) State PA (b) County PA

(c) City or town. La

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4429 Lowell Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

Picker

(c) Social Security Account No. 16

6 (a) Single, married, widowed, or divorced, Single

6 (c) If alive, give age — years

20. DATE OF DEATH Sept. 13 1943 at 4 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 11/19 43 to Sept 13 19 43
and that I last saw him alive on Sept 13 19 43

Immediate cause of death

Chinese migrants to the
Due to

Due to

Other Conditions *Carcinoma of*
Left Breast

Date of operation.

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) **Means of injury.**

23. Signature Chell Strehen

Address 4716 North Parker Date signed 9/1/43 ^{M. D.}

19 (a) _____
(Date rec'd by registrar)

SEP 14 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08137
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 13 1943 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8/43 to 9/13/43, and that I last saw him alive on 9/13/43.

Immediate cause of death

Failure

Due to

General peritonitis

Due to

Undermined Organ

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

General peritonitis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Calvin H. Henson

Address

2316 E. Oliver St.

Date signed

9/13/43

Duration
3 d
PHYSICIAN
Underline the cause to which death should be charged statistically.

SEP 14 1943

6 08138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08138
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address md.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2107 Lenley ST.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Florence Rose Johnson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.Child

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Dec 20, 19398. AGE: Years Months Days If less than one day
3 8 5 23 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation none

11. Industry or business

12. Name Joseph N. Johnson13. Birthplace Greenfield, Ohio14. Maiden Name Emma Smith15. Birthplace Pennsylvania16 (a) Informant Emma Johnson(b) Address 2107 Lenley St17 (a) Burial (b) Date thereof 9-16-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory SchwartzLocation Baltimore, Md.18 (a) Funeral director Quarles & Corington(b) Address 21 W. 25th St19 SEP 14 1943
(Date rec'd by registrar)Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1943, at 8:35 P.21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Occlusion of
right coronary arteryDue to Congenital aneurysm of
aorta

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury _____

23. Signature Robert L. Gratz M.D.
Medical Examiner.Signed Sept. 14, 1943

08139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08139

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James O'Donnell Elder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 30, 1910

8. AGE: Years Months Days

33

2

13

hr.

min.

9. Birthplace

Surry Co., Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

John O'Donnell Elder

13. Birthplace

Va.

14. Maiden Name

Sda. ? Butler

15. Birthplace

Va.

16 (a) Informant

Record.

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

9/16/43

(burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Chas. O. Wilson

(b) Address

1000 Brantley Ave

19 SEP 14 1943

(b) Huntington, Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

421 N. Eden St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 13, 1943, at 9²⁰ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13, 1943, to Sept 13, 1943, and that I last saw him alive on Sept 13, 1943.

Immediate cause of death

Coronary

Occlusion

Duration

45 minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Abraham G. Enecini

Address Johns Hopkins Hospital

Date signed

9/13/43

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08140
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1714 E. Monument

(c) Hospital or institution:

Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 5223 Anthony Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Leonard C. Maygers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary E

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

Sept 1 - 1886

8. AGE: Years Months Days

5

11

12

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

10. Usual Occupation

Fire Inspector

11. Industry or business

United Oil Co

FATHER

12. Name

Charles Maygers

13. Birthplace

Md.

MOTHER

14. Maiden Name

Catherine Hoffman

15. Birthplace

Md.

16 (a) Informant

Mary E. Maygers

(b) Address

5223 Anthony Ave

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof 9-17-43

(month) (day) (year)

(c) Cemetery or crematory

Catharine

Location

Baltimore

18 (a) Funeral director

Leonard Maygers

(b) Address

5305 Waverly

19 (a)

Huntington Williams, M.D.

20. DATE OF DEATH

Sept. 13, 1943, at 4 M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug. 31, 1943 to Sept. 13, 1943.

and that I last saw him alive on Sept. 13, 1943.

Immediate cause of death

Respiratory Failure

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug. 31, 1943 to Sept. 13, 1943.

and that I last saw him alive on Sept. 13, 1943.

Immediate cause of death

Respiratory Failure

Due to

Metastasis to brain

Due to

Myxoliposarcoma

Other Conditions

Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Henry Musumeci

Address

Sinai Hosp

Date signed 9-18-43

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

SEP 14 1943
VS 116

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G 08141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

817

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2104 W. Coldspring Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1804 W. Lafayette

(If rural give location) (Yes or No)

(e) Citizen of foreign country? If yes, name country

3 (a) FULL NAME

Nathaniel B Fullum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

? 1862

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1863

8. AGE:

Years

Months

Days

If less than one day

80

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

Engineer

11. Industry or business

FATHER
MOTHER

12. Name

John J Fullum

13. Birthplace

Ireland

14. Maiden Name

Jane Carty

15. Birthplace

Ireland

16 (a) Informant

Roland Fullum

(b) Address

3326 Dudley Ave.

17 (a)

Burial (Burial, cremation, or removal)

(b) Date thereof

9-12-43 (month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore

18 (a) Funeral director

Leonard G. Park

(b) Address

5305-1 Harford Rd.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1943 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1943 to Sept 12 1943, and that I last saw him alive on Sept 10 1943.

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. W. Fullum

Address

3324 Reisterstown Rd.

Date signed

9/14/43

SEP 14 1943

VB 180

G 08143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08143

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1612 Light Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 602 W. Hamblum

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Albert Thorne Wm. A. Thorne

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 216-01-7189

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Lillian Nahne

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1895

8. AGE: Years Months Days If less than one day

48 7 8 hr. min.

9. Birthplace Balto. Md

10. Usual Occupation Shop Metal Worker

11. Industry or business Shop Metal

12. Name Wm. A. Thorne

13. Birthplace Balto. Md

14. Maiden Name Ella Wetherston

15. Birthplace Balto. Md

16 (a) Informant Wm. A. Thorne

(b) Address 602 W. Hamblum

17 (a) Burial (b) Date thereof 9/16/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium London Park

Location Hopewell Ave

18 (a) Funeral director J. H. Egan

(b) Address 1600 Hollins St.

19 (a) Date of death 14 SEP 1943

(b) Signature of physician

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1943, at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended

deceased from 9/10 1943, to 9/13 1943.

and that I last saw him alive on 9/13 1943.

Immediate cause of death

Lobar pneumonia
(rt. lower lobe)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy as above.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thos. J. Mariano MD

Address 11 Balto Ave Date signed 9/13/43

Duration

10 days

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

440466

BALTIMORE CITY HEALTH DEPARTMENT
G 08144 CERTIFICATE OF DEATH

G 08144
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Evelyn Riggleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-9-43

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Kenneth Riggleman

13. Birthplace

Md

14. Maiden Name

MARGARET ARNOLD

15. Birthplace

Md

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Sept 15, 43
(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

Baltimore, Md

18 (a) Funeral director

Wilton Schilling

(b) Address

3914 S. Hanover St

19 (a) SEP 14 1943

Huntington, West Virginia, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Calvert

(c) City or town

Cedar Hill

(If outside city or town limits, write RURAL and give town)

(d) Street No.

RFD 9 Box 61

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 13

1943, at 6:03 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Sept 13 1943, and that I last saw her alive on Sept 13 1943.

Immediate cause of death Respiratory failure

Due to

Cytic Hygroma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-2-43

Major findings of operation: Mass cystic follicles with lymphoma of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. Lee Randol

Address

Johns Hopkins Hosp

Date signed

9/14/43

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

JE - 08145
82808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08145
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 E. Biddle H.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hennessy
3 (b) If veteran, name war 3 (c) Social Security Account No.
4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 27, 1918
8. AGE: Years Months Days If less than one day
24 11 14 hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER 12. Name John Edward Hennessy
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Elizabeth Rose,
15. Birthplace Baltimore, Md.
16 (a) Informant B. C. E. Records
(b) Address 4940 Eastern Ave.
17 (a) Burial (b) Date thereof Sept. 10, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New North
Location Old Frederick Rd.
18 (a) Funeral director John G. Wilson
(b) Address 3000 E. Baltimore H.

19 SEP 14 1943
Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1943 at 5:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1943 to 9-11 1943, and that I last saw him alive on 9-11 1943.

Immediate cause of death
Pulmonary tuberculosis
Due to
Due to
Other Conditions

Duration
Syr
PHYSICIAN
Underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul H. H. M.D.
Address R. Oct Date signed 9/11/43

G 08146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08146

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1408 PATAPSCO ST.

(c) Hospital or institution:

1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1408 PATAPSCO ST

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME URSULA ANZER

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

FEM.

WHITE

WIDOW

6 (b) Name of husband or wife JACOB ANZER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 18 1863

8. AGE:

Years

Months

Days

If less than one day

80

2

25

hr.

min.

9. Birthplace

GERMANY.

(Town, county, and state)

10. Usual Occupation

HOUSE WORK

11. Industry or business

AT HOME

FATHER

12. Name FREDERICK PAULUS

13. Birthplace GERMANY.

MOTHER

14. Maiden Name NOT KNOWN

15. Birthplace GERMANY

16 (a) Informant JOHN ANZER.

(b) Address 1408 PATAPSCO ST.

17 (a) BURIAL (b) Date thereof 9-16-43

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location

H. A. Co

18 (a) Funeral director Bernard E. Hinkle

(b) Address 121 E. West St.

19 (a) SEP 14 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 12 1943 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 17 1936 to SEPT 12 1943 and that I last saw him alive on SEPT 12 1943.

Immediate cause of death

CORONARY OCCLUSION

Due to ARTERIO-SCLEROSIS
CARDIO VASCULAR RENAL DISEASE

Due to ARTERIO-SCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward J. Hinkle

Address 670 W. Green St. Date signed 9-13-43

Duration

10 days

1936

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

Approved by Howard J. Mallesio, M.D.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08147
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 Hollins St.
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 3/4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Hollins St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Romania Lithuania

3 (a) FULL NAME Stanley Seerianicus
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M 5. Color or race White 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27

8. AGE: Years 59 Months Days If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor
11. Industry or business

FATHER 12. Name P
13. Birthplace Lith
MOTHER 14. Maiden Name P
15. Birthplace Lith

16 (a) Informant Mrs. M. Seerianicus
(b) Address Telephone - CH 3253 W

17 (a) Burial (b) Date thereof Sept 23 - 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cmn
Location Blair Rd

18 (a) Funeral director Joseph Kasinski

19 (a) SEP 14 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1943 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 PM 9/13/43 to 10 PM 9/13/43 and that I last saw him alive on 9/13/43

Immediate cause of death Cerebral aneurysm ruptured (transferring into ventricle)
Due to hypertension and
Due to chronic disease

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature J. A. Ruzicka Jr.
Address University Hospital Date signed 9/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Approved: Robert Lee Graham M.D.

08148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08148
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Roland Hall

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 - 1931

8. AGE: Years Months Days If less than one day

11

09

15

hr.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

School boy

11. Industry or business

FATHER

12. Name Frankie Hall

13. Birthplace

Baltimore Md

MOTHER

14. Maiden Name Violet Northern

15. Birthplace

Baltimore Md

16 (a) Informant Emma Northern

(b) Address 2534 Madison Ave

17 (a) Burial (b) Date thereof 9/16/43

(c) Cemetery or crematory

Gut. Calvary

Location

18 (a) Funeral director

Robert H. Young

(b) Address 804 W. Caroline St.

SEP 14 1943

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1412

Barnes St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-12-

1943

and 5:30 A M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Gun shot wound, left shoulder,
involving spinal cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury May 2-43 at 1:45 A M

(b) Where did injury occur? Caroline St. - Baltimore Ave

(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? No

(d) Means of injury Bullet wound

23. Signature Howard J. Wessels

M.D.

Date signed 9-14-43

Medical Examiner.

G 08149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08149

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced:

Widowed

6 (b) Name of husband or wife

Michael (deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

72. 11

If less than one day

hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw h. alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08150

Registered No.

83a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1436 Battery Ave.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 7
 (e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town line, write RURAL and give town)
 (d) Street No. 1436 Battery Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

August W. Kuhlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Margaret B. Kuhlman6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.)

July 2, 1883

8. AGE:

Years

Months

Days

If less than one day

60210

hr. min.

9. Birthplace

Balto., Md.
(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

William Kuhlman

13. Birthplace

Germany

MOTHER

14. Maiden Name

Henrietta Koch

15. Birthplace

Germany

16 (a) Informant

Mrs. Margaret B. Kuhlman

16 (b) Address

1436 Battery Ave.

17 (a)

Burial
(Burial, cremation, or removal)

17 (b) Date thereof

Sept. 16, 1943
(month) (day) (year)

17 (c)

Western
Cemetery or crematory

Location

Balto., Md.

18 (a) Funeral director

G. Howard Evans

18 (b) Address

1400 S. Charles St.

19 (a)

Registrar

19 (b)

Sept 14 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 12, 1943 at 7:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1943, to Sept 12 1943, and that I last saw him alive on Sept 12 1943.

Immediate cause of death

Chloroform

Due to

Cerebral Hemorrhage

Due to

arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

R. S. CampbellAddress 1644 Hanover

Date signed

9/14/43

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08151

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08151
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1616 N. Caroline street
 (c) Hospital or institution: --
 (d) Length of stay in hospital or inst. (yrs., mos., or days) --
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1616 N. Caroline street
 (If rural give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country.

3 (a) FULL NAME

GEORGE M. SHIPPER

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife

Catherine E. Shipper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 20, 1862

8. AGE: Years

80 81

Months

9

Days

22

If less than one day

hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Rev. Geo. E. Shipper

(b) Address

1616 N. Caroline street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9/15/43

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

18 (a) Funeral

Chas. J. Evans, Inc.

(b) Address

118 N. W. Royal Ave

19 (a)

SEP 14 1943

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 12, 1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from

1941. Sept. 12, 1943.

and that I last saw him alive on Sept. 11, 1943

Immediate cause of death

Arteriosclerotic disease

Due to

Due to

Other Conditions

Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

N. H. Henger

23. Signature

Address 1402 B. L. Lane

Date signed 9.13.43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08152

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison St. & London Ave*

(c) Hospital or institution:

Maryland General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1603 Bolton street*

(If rural give location)

(e) Citizen of foreign country? *NO*

If yes, name country

(Yes or No)

3 (a) FULL NAME

*Mrs Sarah**Warner*

3 (b) If veteran, name war

3 (c) Social Security Account

No. *none*

4. Sex

Female

5. Color or race

*white*6 (a) Single, married, widowed, or divorced. *Widow*6 (b) Name of husband or wife *Frank R. Warner*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1874 ?*8. AGE: Years *69 ?* Months Days If less than one day

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *At home*

11. Industry or business

12. Name *Unknown*13. Birthplace *Unknown*14. Maiden Name *Unknown*15. Birthplace *Unknown*16 (a) Informant *Dr. Charles L. Warner*(b) Address *424 Medical Arts Bldg.*17 (a) *Burial* (b) Date thereof *9/15/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Cathedral*

Location

18 (a) Funeral director *Chas. J. Evans & Son Inc*(b) Address *118 W. Mt. Royal Ave*

19 (a) (Date rec'd by registrar)

(b)

Franklin Williams

Registrar

(c) Means of injury

Signature *John DeYoung Jr.*Address *118 W. Mt. Royal Ave*Date signed *9/11/43*

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 11 1943*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 10 1943* to *Sept 11 1943* and that I last saw him alive on *Sept 11 1943*

Immediate cause of death

Myocardia

Duration

Due to *Hypertension Cordis**Myocardial Disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *None*Major findings of operation: *None*of autopsy: *None*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

Signature *John DeYoung Jr.*Address *118 W. Mt. Royal Ave*Date signed *9/11/43*

SEP 14 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08153

AB-83585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G 08153

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3304 Frederick Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
(Johanna)

Jospehine Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2-1892

8. AGE: Years Months Days If less than one day
61 3 9 hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name Thomas Fitzgerald

13. Birthplace Ireland

14. Maiden Name Margaret Lanord

15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals

(b) Address

17 (a) Burial Records (b) Date thereof 9/16/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral Director Chas. J. Grogan, Son

(b) Address 118 W. Mt. Royal Ave.

SEP 14 1943 (b) (Date of death)

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1943, 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/7 1943, to 9/11 1943
and that I last saw her alive on 9/11 1943.

Immediate cause of death

Pulmonary T.B.C.
Card. failure
Due to H.S. C.V.D.

Due to

Other Conditions ~~Psychosis~~ Sanitary
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

Signature C. J. Seigman

Address 10 C H Date signed 9/13

Physician
Underline the
cause to which
death should be
charged statisti-
cally.

16

08154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

08154

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 815 William St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Anna C. Braecklein

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1880

8. AGE: Years Months Days

If less than one day

62

8

29

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

12. Name Charles Detrick Meyers

13. Birthplace Maryland

14. Maiden Name Alice Pilcher

15. Birthplace Maryland

16 (a) Informant Mrs. Beate Seifert

(b) Address Ferndale, Md.

17 (a) Burial (b) Date thereof 9/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Edmondson Ave

18 (a) Funeral director William M. Marek

(b) Address 710 E. 1st St

19 (a) William M. Marek Registrar

SEP 15 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 815 William St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1943 at 3:10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1943 to Sept. 12 1943, and that I last saw him alive on Sept. 12 1943.

Immediate cause of death

Carcinoma of Breast

Duration

5 yrs.

Due to

Due to

Other Conditions metastases to lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Isaac Miller

Address 122 F.D. Charles St. Date signed 9/13/43

6 Mrs. PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08155

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2813 Roselawn Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **40yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2813 Roselawn Ave.**
(e) Citizen of foreign country (If yes, give location) (Yes or No)
If yes, name country

3 (a) FULL NAME

George T. Webster3 (b) If veteran, name war
----3 (c) Social Security Account
No. **215-09-6277**4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. **Widowed**6 (b) Name of husband or wife **Mary Jane Webster**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan. 28, 1880**8. AGE: Years Months Days If less than one day
63 7 14 hr. min.9. Birthplace **Md.**
(Town, county, and state)10. Usual Occupation **Watchman**11. Industry or business **(Lord Balto. Press)**12. Name **George Webster**13. Birthplace **Md.**14. Maiden Name **Sarah Parkinson**15. Birthplace **Md.**16 (a) Informant **Mrs. Jane Miller**(b) Address **2813 Roselawn Ave.**17 (a) **Burial** (b) Date thereof **Sept. 15/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Baltimore Cem.**Location **Balto. Md.**18 (a) Funeral director **Philip Henry Sam**(b) Address **2024 Orleans St.**19 (a) (b)
(Date and Registrar)

SEP 15 1943

Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 12/43** 19 **at 7:10 A.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 10 1943** to **Sept. 12 1943**, and that I last saw him alive on **Sept. 12 1943**.

Immediate cause of death

Coronary OcclusionDue to **arteriosclerotic cardiovascular**Due to **renal disease**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury **S. A. Alessi M.D.**23. Signature **S. A. Alessi M.D.**Address **6217 Highland Rd** Date signed **9-13-43**

Duration

36 hrs**2 yrs.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

930

G 08156
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anne Erge
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. 5. Color or race W. 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Patrick M. McElvaine
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Smych
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1201 Valley St. Balt. Md.

17 (a) Monte Maria (b) Date thereof Sept 16, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Monte Maria
Location Southern, Md

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) SEP 18 1943
VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1943, at 8:45 am. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 - 1943 to Sept 14 - 1943, and that I last saw her alive on Sept 13 - 1943.

Immediate cause of death

Due to Ecdema Lungs
Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B. G. Hall

Address 1631 E. North Ave Date signed 9/14/43 M. D.

Duration
1 day
1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08157
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 738 W. Fayette St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.

3 (a) FULL NAME

Baby Girl Womeldorph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-7-43

8. AGE:

Years

Months

Days

If less than one day

2 hr. 3

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name

Lawrence Barclay Womeldorph

13. Birthplace

Winchester Vd.

14. Maiden Name

Evelyn Frances Johnson

15. Birthplace

Paris Vd.

16 (a) Informant

Mrs Womeldorph

(b) Address

738 W Fayette

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 14 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

Huntington Williams, M.D.
Registrar

19 SEP 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1943 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1943 to 9-7 1943

and that I last saw her alive on 9-7 1943

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. Alfred K. Kemphrey

Address 2220 Eastern Ave Date signed 9/9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08158

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

3 (a) FULL NAME

James Gilbert Sample

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1943

8. AGE: Years Months Days If less than one day

23

hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Harry Sample

13. Birthplace Leesburg Co., Va.

14. Maiden Name Mabel Lane

15. Birthplace Essex Co., Va.

16 (a) Informant Mabel Sample

(b) Address 26 N. Poppleton St.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 14 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 15 1943 Huntington Williams, M.D.

(Signed by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town Baltimore Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 26 N. Poppleton St.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1943, to 8/28 1943, and that I last saw him alive on 8/28 1943.

Immediate cause of death

Respiratory failure

Due to Dehydration

Due to Acidosis

Due to Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Josephine E. Renshaw

Address Univ. Hospital

Date signed 8/28

M. D.

VB 144

F 0356

08159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08159

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

516 Bruce St

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 year

(e) Length of stay in Baltimore (yrs., mos., or days)

1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

516 Bruce St. BRUNE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby girl

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

female

5. Color or race

colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 8, 1943

8. AGE:

Years

Months

Days

If less than one day

1 mo

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Samuel Gross

13. Birthplace

St. Marys Co - Md

14. Maiden Name

Isabella Ringold

15. Birthplace

Baltimore, Md.

16 (a) Informant

Samuel Gross

(b) Address

516 Bruce St.

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

UNIVERSITY MEDICAL SCHOOL SEP 14 1943

Location

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 15 1943

(b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/8/43

19

at 8:30 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 9/1/43 19 to 9/8 1943.

and that I last saw her alive on 9/7 1943.

Immediate cause of death

Resp. failure

Due to

prematurity

Due to

diphtheria

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams, M.D.

Address

Univ. Hospital

Date signed

M. D.

7/9

08160

G 08160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Green Sts.*

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *13 hr + 10 min*(e) Length of stay in Baltimore (yrs., mos., or days) *13 hr + 10 min*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *9-12-43*

8. AGE:

Years

Months

Days

If less than one day

13 hr.*10* min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Martin Reed, Jr.

13. Birthplace

Norton, Va.

MOTHER

14. Maiden Name

Ruby Estes

15. Birthplace

Colburn, Va.

16 (a) Informant

Mrs. Ruby Reed

(b) Address

Moocher

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 14 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

*Stuntington Williams, M.D.*SEP 15 1943
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md. Va.

(b) County

(c) City or town

University Hospital

(If outside city or town limit, write RURAL and give town)

(d) Street No.

Norton, Va. Redwood St.

(e) Citizen of foreign country?

(If rural, give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9-13-43**8:30 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *9-12-43* 19 to *9-13-43* 19, and that I last saw her alive on *9-12-43* 19.Immediate cause of death *unknown*

Duration

Due to

(see)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Raymond J. C. Bingle

Address

University Hospital

Date signed

9-13-43

161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08161

Registered No.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Wilson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex m 5. Color or race c 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1943

8. AGE: Years Months Days If less than one day 12 hr. min.

9. Birthplace Balt, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

12. Name Anna Wilson

13. Birthplace Hong Kong

14. Maiden Name Elizabeth Herbert

15. Birthplace Victoria, B.C.

16 (a) Informant Mrs. Elizabeth Wilson
(b) Address 1626 E. Chase St

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 14 1943

18 (a) Funeral director Commissioner of Health

SEP 15 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1943 at 2:28 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Sept 4 1943 to Sept 11 1943 and that I last saw him alive on Sept 11 1943.

Immediate cause of death

Premature Birth
Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Ralph W. Perkins
Address 406 N. ... Date signed 9/11/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08162
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Bessie Lillian Bissinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female white

Widowed

6 (b) Name of husband or wife

Gustave

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-24-62

8. AGE: Years

Months

Days

If less than one day

81

7

20

hr.

min.

9. Birthplace

Col.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John T. Rice

13. Birthplace

Eng.

14. Maiden Name

Eliza Nodham

15. Birthplace

Eng.

16 (a) Informant

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Cremation

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Crematory

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

(b) *Frederick William Williams, M.D.*
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2002 NE Royal Terrace

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 14 1943 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1943 to Sept. 14 1943 and that I last saw him alive on Sept. 14 1943

Immediate cause of death

Cardiac

Jaundice

Due to

irritation

Due to

Carcinoma of Sigmoid Colon

Other Conditions

Pyelitis Paratuberculous

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. S. Cross Jr

Address J. H. H.

Date signed 9-14-43

SEP 15 1943

08163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08163
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 639 S. Decker ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 639 S. Decker ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Lea Patric Cummins

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-01-276120

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Veronica Cummins

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.)

Sep 25 1917

8. AGE:

Years

Months

Days

If less than one day

25

11

20

9

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

A.A. Chemical Co.

FATHER
MOTHER

12. Name William Cummins

13. Birthplace Baltimore Md.

14. Maiden Name Caroline Lepke

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Veronica Cummins

(b) Address 639 S. Decker ave

17 (a) Burial

(b) Date thereof Sep 18 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Sacred Heart Cemetery

Location Baltimore County

18 (a) Funeral director

John W. Welch

(b) Address

401 S. Chester Street

19 SEP 15 1943

Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 14 1943 at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to 9/13 1943

and that I last saw him alive on 9/13 1943

Immediate cause of death Cardiac failure

Duration

Due to phrenetic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Frank R. Munn

M. D.

Address 773 S. East Ave

Date signed 9/14/43

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08164

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08164

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Green Redwood St*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *15*

(e) Length of stay in Baltimore (yrs., mos., or days) *39 yrs*

3 (a) FULL NAME

Mr. Benjamin Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

w

6 (b) Name of husband or wife *Late Jennie*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb 4 1885*

8. AGE:

Years

Months

Days

If less than one day

58

7

11

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

none

FATHER

12. Name

Martin Jacobs

13. Birthplace

Russia

MOTHER

14. Maiden Name

Rose Singer

15. Birthplace

Russia

16 (a) Informant

Mr Morris Engel

(b) Address

2107 Bryant Ave

17 (a) *Burial*
(Burial, cremation, or removal)

(b) Date thereof *Sept 16/43*
(month) (day) (year)

(c) Cemetery or crematory

Hebrew Acre

Location

Hamlet Ave.

18 (a) Funeral director

Sol Levine Bros

(b) Address

124-26 W 9th St

19 (a)

SEP 15 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County

(c) City or town *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2107 Bryant Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/15 1943

21. I certify that death occurred on the date above stated; that I attended deceased from *8/29 1943* to *9/13 1943* and that I last saw him alive on *9/16 1943*.

Immediate cause of death

Pulmonary Edema

Duration

Due to

Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

S. L. Lench

Date signed *9/19/43*

Univ. Hosp. Redwood Home Sta.

08165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08165

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 002

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1404 Carroll St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME WILLIAM LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

col

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 19258. AGE: Years 18 Months - Days 11 Less than one day hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name William Lee13. Birthplace N.C.14. Maiden Name Jeanette Hill15. Birthplace N.C.16 (a) Informant Jeanette Lee(b) Address 1404 Carroll Street17 (a) Burial (b) Date thereof 9/15/43
(Burial, cremation, or removal) (month) day (year)(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore, Maryland18 (a) Funeral Rev. F. Elliott's daughter(b) Address 1129 N. Caroline St.19 (a) SEP 15 1943 William Lee
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12, 1943 at 2 A.M.21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9/12/43 at 2(b) Where did injury occur Javern, Louis. Ellison
Vincent & Cairo StsDid injury occur at home, on farm, industrial place, in public
place? public While at work? no(d) Means of injury Shot during altercation23. Signature R. D. Wallenrothe M.D.Date signed 9-12-43
Cook Medical Examiner.

08166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08166
Registered No.

AB-81443

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos., -1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) ~~MD~~ Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2110 Druid Hill Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

3 (a) FULL NAME

Dennis Lewis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-27-1887

8. AGE: Years 55 56 Months 11 Days 16 14 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Sipp Lewis

13. Birthplace Va.

14. Maiden Name Lillie Brown

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address records

17 (a) Burial (b) Date thereof Sept 15, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.
Location Annapolis, Md.

18 (a) Funeral director Mrs. Robert G. Elliott & Daughter

(b) Address 1124 N. Caroline St.

19 (a) Sep 13 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1943, at 2:06 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943, to 9/12 1943, and that I last saw him alive on 9/12 1943.

Immediate cause of death:

Pneumonia, left lobe

Duration

?

Due to

Due to

Other Conditions Amyotrophic lat. sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sargman

Address B C H Date signed 9/13

correct age is especially important. Every item of information should be carefully secured. Physicians: please write the causes of death clearly and legibly.

G 08167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1129 Gilman St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

John Kiah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Hannela Kiah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 2, 1873

8. AGE:

Years

Months

Days

If less than one day

70

7

12

hr.

min.

9. Birthplace

Dorchester Co. Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Anthony P. Kiah

13. Birthplace

Dorchester Co. Md.

14. Maiden Name

Hannela Kiah

15. Birthplace

Dorchester Co. Md.

16 (a) Informant

Healey Martin

(b) Address

1129 N. Gilman St

17 (a)

Burial

(b) Date thereof

9/15/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

St. Paul's Church, Md.

18 (a) Funeral director

Chas. Alexander

(b) Address

927 N. Mount St.

19 (a)

(b)

(Date of registration)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1129 N. Gilman

(If surrogative location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 14 1943 at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1942 to Sept 14 1943, and that I last saw him alive on Sept 13 1943.

Immediate cause of death

Cardio Vascular Disease

Due to

Hypertension

Due to

Hemiplegia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. William F. Day

Address 1908 Pa Ave

Date signed

M. D.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

SEP 15 1943

H. W. Williams

G 08168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08168

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 318 Lyndhurst St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

7

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

George F. Engel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 23, 1894

8. AGE:

Years

Months

Days

49

1

20

If less than one day

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Samuel W. Curville

13. Birthplace

Va.

MOTHER

14. Maiden Name

Frances Linick

15. Birthplace

Baltimore, Md

16 (a) Informant

George F. Engel

(b) Address

318 Lyndhurst St

17 (a)

Burial

(b) Date thereof Sept 15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore, Md

18 (a) Funeral director

Harry A. White

(b) Address

41016 Edmondson Ave

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

318 Lyndhurst St

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 13 1943 at 4:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to Sept 13 1943, and that I last saw him alive on Sept 12 1943.

Immediate cause of death

Chronic Myocarditis

Due to

Hypertension

Due to

Obesity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

D. Walter Spumer

Address

3603 Edmondson Ave

Date signed 9/14/43.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 15 1943

G 08169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08169

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 3604 Spaulding Ave.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 3604 Spaulding Ave
(rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Amelia E. Eader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

w.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.)

Mar 15, 1876

8. AGE:

Years

Months

Days

If less than one day

77527

hr.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

John W. Eader

13. Birthplace

Md

MOTHER

14. Maiden Name

Mary E. Warfield

15. Birthplace

Md

16 (a) Informant

Mrs. Nellie M. Alvey

(b) Address

3604 Spaulding Ave

17 (a) Burial

(b) Date thereof

Sept 15/43
(month) (day) (year)

(c) Cemetery or crematory

WesternBaltimore Md

18 (a) Funeral director

Harry H. Witzke

(b) Address

41015 Almond Ave

19 (a)

(Date)

SEP 15 1943

(b)

Register for Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12 1943 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1943 to Sept. 12 1943, and that I last saw him alive on Sept 11 1943.

Immediate cause of death

1. Arterio Sclerosis
Heart Disease

Due to

Due to

Other Conditions

Laceration of scalp
due to fall

(Include pregnancy within 8 months of death)

Date of operation

None

Major findings of operation

None

of autopsy

None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Earl L. Chambers

M. D.

Address 41015Liberty St.Date signed 9/15/43

correct age is especially important. Every item of information should be carefully supplied. With UNFADING INK. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08170
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1617 N. Mountford an

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1617 N. Mountford an

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Theresa Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23-1890

8. AGE:

Years

Months

Days

If less than one day

53

5

21

hr.

min.

9. Birthplace Brooklyn N. Y.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John M. Bond

13. Birthplace Brooklyn N. Y.

14. Maiden Name Mary Alice Ham

15. Birthplace Brooklyn N. Y.

16 (a) Informant Lillian Bond

(b) Address 1617 N. Mountford an

17 (a) Burial (b) Date thereof Sept 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balair Road

18 (a) Funeral director John C. Moran

(b) Address 3800 E. Baltimore St

19 (a) SEP 15 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1943 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1943 to Sept 13 1943 and that I last saw her alive on Sept 13 1943

Immediate cause of death

Myocardial Infarction

Duration

2 mos

Due to Arterio Sclerosis and

Hypertension

4 mos

4 mos

Due to Chronic Interstitial Nephritis

4 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. P. Stevens

Address 2878 Harford Rd Date signed 9/14/43

G 08171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08171
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **Payette & Paulaski Sts.**
 (c) Hospital or institution: **Ben Secours Hospital**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **3 days**
 (e) Length of stay in Baltimore (yrs., mos., or days) **35 Yrs.**

3 (a) FULL NAME

Mr. Louis Wade Sr.

3 (b) If veteran, name war

3 (c) Social Security Account
No. **217-03-4589**

4. Sex

Male

5. Color or race

Wht.6 (a) Single, married, widowed, or divorced.
Married6 (b) Name of husband or wife **Ella G. Wade**6 (c) If alive, give age **39** years7. Birth date of deceased (mo., day, yr.) **April 23, 1884**

8. AGE:

59

Years

Months

4

Days

21

If less than one day

hr.

min.

9. Birthplace **A.A.Co. Md.**

(Town, county, and state)

10. Usual Occupation **Carpenter**11. Industry or business **Construction**12. Name **Wm. Wade**13. Birthplace **A.A.Co. Md.**14. Maiden Name **Elizabeth Wheeler**15. Birthplace **A.A.Co. Md.**16 (a) Informant **Mrs. Ella G. Wade**(b) Address **2225 Penrose Ave.**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Sept. 17, 1943**

(month) (day) (year)

(c) Cemetery or crematory **Cedar Hill**Location **A.A.Co. Md.**18 (a) Funeral director **Robert S. Little**(b) Address **2700 Edmondson Ave.**19 **SEP 15 1943***Handwritten signature*

2. USUAL RESIDENCE OF DECEASED:

(a) **9th Md.** (b) County **444**(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **2225 Penrose Ave.**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 14** 19**43**, at **12¹⁵** P.M.21. I certify that death occurred on the date above stated; that I attended deceased from **9-11** 19**43** to **9/14** 19**43**, and that I last saw him alive on **9/14** 19**43**.

Immediate cause of death

Gastric Hemorrhage

Duration

4 days

Due to

Gastric ulcer

Due to

Other Conditions

Arteriosclerotic C-V. Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy **Same**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Edward L. J. Kuep**

M. D.

Address **Ben Secours Hosp** Date signed **9-14-43**

G 08172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08172

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.

1405

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

David Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

M

B

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 30 - 1943

8. AGE:

Years

Months

Days

If less than one day

1

13

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Daniel Scott

13. Birthplace

14. Maiden Name

Dorothy Turner

15. Birthplace

Baltimore, Md.

16 (a) Informant

Dorothy Turner

(b) Address

1405 Cairo St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Sept 15 - 43

(c) Cemetery or crematory

Mt Zion Cem.

Location

18 (a) Funeral director

Mrs Kate R. Williams

(b) Address

322 N. Sepoche St.

19 (a)

(Date and place of burial)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/13

1943, at 8:30 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from 9/13 1943 to 9/13 1943, and that I last saw him alive on 9/13 1943.

Immediate cause of death

Aspiration of feeding
Asphyxiation

Duration

Due to

Due to

Other Conditions

Diarrhea (with fever)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Cohen

Address

University Hosp.

Date signed 9/13/43

correct age is especially important. Every item of information should be carefully written in UNFADING INK. Physicians: please write the causes of death clearly and legibly.

SEP 15 1943

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08173

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1803 W. Mulberry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1803 W. Mulberry St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Daisy L. Alisea

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Frank Alisea

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug 27th, 1873

8. AGE: Years Months Days If less than one day

70

-

15

hr.

min.

9. Birthplace Leesburg, Va.

(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

12. Name John Galleher

13. Birthplace Va.

14. Maiden Name Virginia L. Bosse

15. Birthplace Va.

16 (a) Informant Hazel Klein

(b) Address 15 S. Arlington Ave.

17 (a) Burial (b) Date thereof 9/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Washington Blvd.

18 (a) Funeral director

(b) Address 1200 W. Lombard

19 (a)

(Date of registration) Sept 15, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12th 1943 2:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to 9/12/43

and that I last saw him alive on 9/12/43

Immediate cause of death

Carcinoma of stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature Benjamin Miller

Address 2030 W. Lombard

Date signed 9/15/43

Duration

6 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 15 1943

G 08174
441119BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08174

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HARRY W. LAWRENCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

ANNA M

6 (c) If alive, give age years

70

7. Birth date of deceased (mo., day, yr.)

9-12-69

8. AGE:

74

Years

Months

3

Days

If less than one day

hr.

min.

9. Birthplace

NEBRASKA

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

WILLIAM LAWRENCE

13. Birthplace

14. Maiden Name

ANNA M. McPHERSON

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Sept-18-43

(month) (day) (year)

(c) Cemetery or crematory

Parkview

Location

Baltimore

18 (a) Funeral director

Leonard J. Phibbs

(b) Address

4705 Hanford Rd

SEP 15 1943

(Date recorded by)

H. H. Hospital Registrar

VS 188

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

PARKVILLE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2908 LINWOOD AVE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 15

1943, at 100 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1943, to Sept 15 1943, and that I last saw him alive on Sept 15 1943.

Immediate cause of death

Hemia &

pulmonary edema

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Inoperable

Ca. of bladder

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James A. Singiser

Address

H. H. Hospital

Date signed 9/15/43

08175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08175

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution:

South Balto. Genl. Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3629 Elkader Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

NANA V Sterner (STEINER)

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Herman Sterner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 24 1886

8. AGE:

Years

Months

Days

If less than one day

57119

hr.

min.

9. Birthplace

Rose Hagerstown Ind

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at homeFATHER
MOTHER

12. Name

Abraham N. Sterner

13. Birthplace

Ind

14. Maiden Name

Sarah E. Smith

15. Birthplace

Ind

16 (a) Informant

Mr. Herman Sterner

(b) Address

3629 Elkader Rd

17 (a)

Burial

(b) Date thereof

Sept. 16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Londox Park

Location

Balto. Ind

18 (a) Funeral director

Geo. E. Berger Jr

(b) Address

1512 Hallings St

19

SEP 15 1943Wm. Williams M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1943, at 11 P M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Toxemia due to2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept. 11 1943 2 P M(b) Where did injury occur Long Point, Magdalen Island

(c) Did injury occur at home, on farm, industrial place, in public

place? Summer cottage While at work? no(d) Means of injury Clothes caught fire from stove23. Signature Robert L. Graham M.D.Date signed Sept. 14 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08176

MACCENTELLI
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08176
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison St + Fensler Ave*

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 month 2 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *24 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *303 S. Fagle St.* *Fagley*
(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Anna Maccentelli

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. *none*

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife *Isaia Maccentelli*

6 (c) If alive, give age *57 years*

7. Birth date of deceased (mo., day, yr.) *May 3rd 1891*

8. AGE: Years Months Days If less than one day

52

4

11

hr.

min.

9. Birthplace *Italy*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business *home*

12. Name *Giovanni Bifoni*

13. Birthplace *Italy*

14. Maiden Name *Maria Lorenzini*

15. Birthplace *Italy*

16 (a) Informant *Jerry Maccentelli (Son)*

(b) Address *303 S. Fagle St.*

17 (a) *Burial* (b) Date thereof *Sept. 17/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer*

Location *Belair Rd. Balt. Md.*

18 (a) Funeral director *Frank Della Noce*

(b) Address *52 N. Morley St.*

SEP 15 1943
(Date of death) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/14 1943* at *8:45 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/11 1943* to *9/14 1943* and that I last saw him alive on *9/14 1943*

Immediate cause of death

Carcinoma of stomach & metastasis to liver & stomach nodes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *7/29/43*

Major findings of operation: *Carcinoma of stomach & metastasis to liver*
of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature *John DeFuria Jr.*

Address *Red. Sun. Hays* Date signed *9/14/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08177

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1040 Argyle Ave.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *17*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.* (b) County(c) City or town *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1040 Argyle Ave.*

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry Royal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 1, 1884

8. AGE:

Years

Months

Days

If less than one day

*58 59**9**13*

hr.

min.

9. Birthplace

Richmond Va.

(Town, county, and state)

10. Usual Occupation

Gardener

11. Industry or business

12. Name

William Royal

13. Birthplace

Va.

14. Maiden Name

Esther Woolridge

15. Birthplace

Va.

16 (a) Informant

Thomas Royal, brother

(b) Address

4223 18th St Phila. Pa.

17 (a)

Burial

(b) Date thereof

9/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Richmond

Location

Richmond Va.

18 (a) Funeral director

Adolphus Balstead

(b) Address

918 Duval Hill Ave.

SEP 15 1943

(b) *Thurston Williams*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 14, 1943, at 1:15 P.M.*21. I certify that death occurred on the date above stated, that I attended deceased from *Sept. 1, 1942* to *Sept. 14, 1943* and that I last saw him alive on *Sept. 14, 1943*.

Immediate cause of death

Acute Heart Dist. Int.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Chas. T. Woodland*
Address *861 Harlem Ave.* Date signed *9/17/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08178
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Delores Emma Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

B

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4/15/1941

8. AGE: Years Months Days

2

4

29

If less than one day

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Stanley Briscoe

13. Birthplace Balto. Md.

14. Maiden Name Naomi Warren

15. Birthplace 565 1/2 Orchard St.

16 (a) Informant Naomi Briscoe

(b) Address 565 1/2 Orchard St.

17 (a) Burial (b) Date thereof 9/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Anne Arundel Co. Md.

18 (a) Funeral director Adolphus Balstead

(b) Address 918 Druid Hill Ave.

19 SEP 15 1943 (Date registered)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

565 1/2 Orchard St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/14

1943 at 2 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1943 to 9/14 1943,

and that I last saw her alive on 9/14 1943.

Immediate cause of death

Acute Toxic reaction from Acute Bacillary Dysentery???

Due to

Due to

Other Conditions

Aspiration of Vomitus

Date of operation

Major findings of operation: Marked aspiration

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Cohen

Address

University Hosp.

Date signed

9/14/43

SEAL - WRITER PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08179
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6437 N. Paca St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County:(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6437 N. Paca St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country:

3 (a) FULL NAME

Albert Moore Phillips

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-10-5246

4. Sex

m

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

1895

8. AGE: Years

58

Months

Days

If less than one day

hr.

min.

9. Birthplace

Oklahoma

(Town, county, and state)

10. Usual Occupation

Janitor

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Mrs. Margaret Hatfield

(b) Address

6437 N. Paca St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 9/16/43

(month) (day) (year)

(c) Cemetery or crematory

Mt. CalvaryLocation Anne Arundel Co. Md.

18 (a) Funeral director

Adolphus Halstead

(b) Address

918 Druid Hill Ave.

SEP 15 1943

(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 11, 1943, at 11 A.M.21. I certify that death occurred on the date above stated that I attended deceased from 8/19/43 to 9/11/43 and that I last saw him alive on 9/11/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M.D.

CAUTION—WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08180
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Prudent Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Laurel St
(e) Citizen of foreign country? No
If yes, name country

3 (a) FULL NAME

Sally Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/28/43

8. AGE: Years Months Days If less than one day
14 hr. min.

9. Birthplace Prudent Hospital
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Taylor
13. Birthplace

MOTHER 14. Maiden Name Mary Smith
15. Birthplace

16 (a) Informant Father Joseph Taylor
(b) Address 527 Laurel St

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1943
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 15 1943 Huntington Williams, M.D.
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/43 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1943 to 9/10 1943.
and that I last saw him alive on 9/10 1943.

Immediate cause of death

Due to pregnancy (placental path)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. Jackson

Address 6004 Adington Ave 9/10

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08181

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Registrar

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 15 1942

VS 100

Registrar

G 08182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08182

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 507 Chapel Gate Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 Chapel Gate Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Arthur V. Stehl

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Florence M. Stehl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1870

8. AGE: Years Months Days If less than one day

73

1

7

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Confectionary

11. Industry or business Proprietor

12. Name Justis Stehl

13. Birthplace Baltimore, Md.

14. Maiden Name Eliza Wilson

15. Birthplace England

16 (a) Informant Mrs. Robert Hancock

(b) Address 507 Chapel Gate Lane

17 (a) Burial (b) Date thereof Sept. 16, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Md.

18 (a) Funeral director E. Willis Hamrean

(b) Address 1025 W. Baltimore St.

SEP 15 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1943, at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 12, 1943, to Sep. 13, 1943.

and that I last saw him alive on Sep. 12, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

3 years

Due to Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Eugene L. Pearson

M. D.

Address 514 Drury Lane

Date signed 9/12/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08183

T.N. 80773

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1460 Battery Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Mercer

3 (b) If veteran, name war

3 (c) Social Security Account

No. 225-10-4176

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

White

Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1881

8. AGE: Years

Months

Days

If less than one day

61

9

10 20

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Jessie Mercer (D)

13. Birthplace Va.

14. Maiden Name Betty (D)

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (records)

17 (a) Burial

(b) Date thereof (month) (day) (year)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location Middlebury Co. Va.

18 (a) Funeral director Mamie Cook Syfer

(b) Address 1600 W. North Ave

19 SEP 16 1943

VB 136

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-15

1943

at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1943 to 9-15 1943.

and that I last saw him alive on 9-15 1943.

Immediate cause of death

Carcinoma of Lung
(superior sulcus)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

6-15-43

Major findings of operation:

superior sulcus tumor

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Donald P. Helt

Address

Balti City Hosp

Date signed

9-15-43

The correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08184

AB-82471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08184
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 608 Glenolden Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Frederick Kissner

3 (b) If veteran, name war

3 (c) Social Security Account
No. 213-10-7504

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-7 (727)

8. AGE: Years Months Days If less than one day

72 7

7

7

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

12. Name Frederick Kissner

13. Birthplace Md.

14. Maiden Name Elizabeth Fisher

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Redords

17 (a) Burial (b) Date there Sept. 17, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto., Md

18 (a) Funeral director Robert S. Little

(b) Address 2700 Edmondson Ave,

SEP 16 1943

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1943 7:43 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1943 to 9-13 1943 and that I last saw him alive on 9-13 1943

Immediate cause of death

Due to Carcinoma of Prostate with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Bell

Address Balto City Hosp Date signed 9-15-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH08185
Registered No.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Layman & Ireland Ave*(c) Hospital or institution
West Balto. General(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 wks*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

*EDWARD
LOUIS ENSOR*

3 (b) If veteran, name war

(c) Social Security Account
No. *116E*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Widowed*6 (b) Name of husband or wife *Elizabeth Ensor*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 26 - 1907*

8. AGE:

Years

Months

Days

If less than one day

*76**1**19*

hr.

min.

9. Birthplace *Balto. Co. Md.*

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

*Farmer*FATHER
MOTHER

12. Name

Geo. G. Ensor

13. Birthplace

Unknown

14. Maiden Name

Maria Lloyd

15. Birthplace

*Balto. Co. Md.*16 (a) Informant *Mrs. Maria Barman*(b) Address *237 N. Calver St.*17 (a) *Burial* (b) Date thereof *Sept 17 1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Green Mount*Location *Balto. Md.*18 (a) Funeral director *William Cook Inc.*(b) Address *257 N. Paul St.*19 (a) *SEP 18 1943* (b) *Huntington Williams, 1100 N. High St. Balto. Md. 9/13/43*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balto*(c) City or town *Pikesville*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/15/43* 19 *43* at *6:30* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *8/31/43* to *9/15/43* and that I last saw him alive on *9/15/43*

Immediate cause of death

*Respiratory failure*Due to *Uremia*Due to *Chronic glomerular nephritis?*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Isadore Strophius*
Isadore Strophius, M.D., 1100 N. High St. Balto. Md. 9/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

THESE ARE TO BE FURNISHED BY THE DECEASED OR HIS NEAREST RELATIVE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 12th G 08186
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Harvey
3 (b) If veteran, name war
3 (c) Social Security Account No 215-10-9329

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Annie M. Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15th 1874
8. AGE: Years 69 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Baley & Co

12. Name Edward Harvey

13. Birthplace Balto, Md.

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Clara Dopper

(b) Address 1219 Scott St.

17 (a) Burial (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Oliver
Location Balto, Md.

18 (a) Funeral director William Cook & Son

(b) Address 1217 St. Paul St.

19 (a) SEP 18 1943 (b) William Cook & Son Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 9-14 1943 at 3⁴⁵ P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1943 to 9-14 1943, and that I last saw him alive on 9-14 1943.

Immediate cause of death Intestinal obstruction ??
Coronary Arteriosclerosis ??

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature Joseph H. Lankaitz M. D.

Address Franklin Square Date signed

1090

G 08187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08187
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) X

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 16 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1943 at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1941 to 9/14 1943, and that I last saw him alive on 9/12 1943.

Immediate cause of death

metastasis senilis

Due to Chronic Myocarditis

Due to general arteriosclerosis

Other Conditions Chr. Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature J. A. Rosenblatt

Address 3078 O'Donnell St. Date signed 9/15/43

Duration

Unknown

Unknown

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

PLEASE PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08188
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Howard & Madison*

(c) Hospital or institution:

Mr. Ben Hoop

(d) Length of stay in hospital or inst. *7* (days)

(e) Length of stay in Baltimore (yrs. *20*)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *725 N. Chester St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph Cilento

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 31, 1869*

8. AGE: Years *73* Months *10* Days *13* If less than one day, hr. min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Clerk - retired

11. Industry or business

FATHER
MOTHER

12. Name *Rachel Cilento*

13. Birthplace *Italy*

14. Maiden Name *Dont Run*

15. Birthplace

16 (a) Informant *Mrs. Adeline Cilento*

(b) Address *725 N. Chester St.*

17 (a) *Buried* (b) Date thereof *Sept 17/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Balto Cem*
Location *Balto, Md*

18 (a) Funeral director *Ullrich Funeral Home*

(b) Address *2008 Orleans St*

19 (a) *SEP 16 1943* (b) *Pharmacist Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 14 1943* at *7:10* M

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 13 1943*, to *Sept 14 1943*, and that I last saw him alive on *Sept 13 1943*.

Immediate cause of death

Right ventricular failure with mitral stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *H. Herman Williams* M. D.

Address *Mr. Ben Hoop* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Sept. 14, 1943

G 08189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08189

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date and by registrar)

(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1943 to Sept 18 1943 and that I last saw him alive on Sept 13 1943.

Immediate cause of death

Coronary Thrombosis

Duration

1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 16 1943

Huntington Williams, M.D.

G 08190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08190
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *3816 East Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *26*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3816 East Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Harry C Jordan

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

*White*6 (a) Single, married, widowed, or
divorced.*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

Fruit Packing

11. Industry or business

Gibbs Packing Co

12. Name

Harry Jordan

13. Birthplace

Ireland

14. Maiden Name

Don't Know

15. Birthplace

Ireland

16 (a) Informant

Mrs Elizabeth Czika

(b) Address

3816 East Ave

17 (a)

burial

(b) Date thereof

Sept 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

Eastern Ave Balto Co Md

18 (a) Funeral director

Ullrich Funeral Home

(b) Address

2008 Orleans St

19

SEP 16 1943(b) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 15* 19*43*, at *4A* M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *Oct 15* 19*42* to *Sept 15* 19*43*
and that I last saw him alive on *Sept 14* 19*43*

Immediate cause of death

Coronary Thrombosis

Due to

Duration

11 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Argue Zeller, M.D.

Address

*2729 Eastern Ave*Date signed *9/15/43*correct age is especially important. Every item of information should be carefully supplied. Do not
FADING INK. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

439215
G 08191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08191
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

13

3 (a) FULL NAME

George Benjamin Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-18-82

8. AGE:

Years

Months

Days

If less than one day

60

11

26

hr.

min.

9. Birthplace

N.Y.

(Town, county, and state)

10. Usual Occupation

Porter

11. Industry or business

12. Name

HENRY THOMAS

13. Birthplace

N.Y.

14. Maiden Name

Ellen Muse

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

9/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Phytos Memorial

Location

Phytos, Md.

18 (a) Funeral director

Charles E. Law

(b) Address

802 Harlem Ave.

19

SEP 16 1943

William H. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2518 McCulloh

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 14 1943, 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1943 to Sept 14 1943, and that I last saw him alive on Sept 14 1943.

Immediate cause of death

Uremia & Renal Failure

Due to

Blocked ureters

Due to

Carcinoma of urinary bladder

Other Conditions

Benign Prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Ureters, sigmoidostomy

Major findings of operation

8/10/43 & 9/8/43 (12 & 24 hrs) Cancer

of autopsy

Duration

1 month

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Walter H. Plummer

Address

1800 N. Charles

Date signed

9/16/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08192

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Madison and Linden Av.*
(c) Hospital or institution: *Maryland General Hosp.*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *50 yds.*
(e) Length of stay in Baltimore (yrs., mos., or days) *50 yds.*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County
(c) City or town *Balto.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3416 Tremont St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) FULL NAME

Mrs Mary A. Hoshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *M*

6 (b) Name of husband or wife *John B. Hoshall*
6 (c) If alive, give age *61* years

7. Birth date of deceased (mo., day, yr.) *Jan 27, 1882*

8. AGE: Years *61* Months *7* Days *19* If less than one day
hr. min.

9. Birthplace *Pa.*
(Town, county, and state)

10. Usual Occupation *Housewife.*

11. Industry or business

12. Name *Francis Wilson.*

13. Birthplace *Ireland*

14. Maiden Name *Unknown*

15. Birthplace *Unknown*

16 (a) Informant *Lorora J. Spann.*

(b) Address *735 Bay St.*

17 (a) *Burial* (b) Date thereof *Sept 20/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Woodlawn.*
Location

18 (a) Funeral director *Chenoweth & Sonoran*

(b) Address *3615-17 Chestnut Ave*

19 (a) *SEP 16 1943*

Franklin W. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-16-43* at *5:30 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8-5-43* 19 *9-16-43* 19
and that I last saw him alive on *Sept 15, 1943*

Immediate cause of death
Myocardial Ca.

Due to *(fem)*

Due to

Other Conditions *Hyper tension*
Venous thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *Thomas Clyde W. White*

Address *1111 N. General Hosp.* Date signed *9/16/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 X ✓ G 08193
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *North Broadway*
(c) Hospital or institution: *Church Home & Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 mos. +*
(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*
(c) City or town *Balto.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1902 Snyder Ave (Dundalk)*
(If rural give location)
(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country.

3. (a) FULL NAME

Mrs. Mary E. Pollheim

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. *No*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan 21, 1885*

8. AGE: Years *58* Months *7* Days *24* If less than one day hr. min.

9. Birthplace *Balto. Md.*

(Town, county, and state)

10. Usual Occupation *Homemaker*

11. Industry or business

12. Name *John Booker*

13. Birthplace *Balto.*

14. Maiden Name *Caroline Stamp*

15. Birthplace *Balto.*

16 (a) Informant *Mrs. Mary E. Pollheim*

(b) Address *as above*

17 (a) *Burial* (b) Date thereof *Sept 15, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Baltimore Ceme*
Location *North Ave & River St*

18 (a) Funeral director *C. C. Schimmey*

(b) Address *2601 E. Madison St*

19 (a) (b)

(Date rec'd by registrar)

Registrar

SEP 16 1943 *William M. Miller*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 14* 19 *43* at *11:05 AM*

21. I certify that death occurred on the date above stated that I attended deceased from *April 30 1942* to *Sept 14 1943*, and that I last saw him alive on *9/14* 19 *43*.

Immediate cause of death
*Arteriosclerotic nephritis
& cardiac failure.*

Due to

Due to

Other Conditions *Diabetes mellitus*

(Include pregnancy within 3 months of death)

Date of operation *#*

Major findings of operation:
Amputation of rt. leg.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Legg*

Address *Church Home & Hospital* Date signed *9/14/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08194
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2813 Mayfield Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2813 Mayfield Ave

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

WILLIAM

W

KERNER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6 = 1884

8. AGE: Years Months Days If less than one day

59 58 4 8 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Bank Clerk

11. Industry or business

12. Name George Kerner

13. Birthplace Baltimore

14. Maiden Name Emma Schmidt

15. Birthplace Baltimore

16 (a) Informant Miss Ida Kerner

(b) Address 2813 Mayfield Ave

17 (a) Burial (b) Date thereof Sep 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore

Location N. North Ave

18 (a) Funeral director Henry Lutz

(b) Address 1203 N. Broadway

SEP 18 1943
(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1943 at 7:30 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of head

Due to Insolutional melancholia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 9-14-43 at 7:30 PM

(b) Where did injury occur? above address

(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work?

(d) Means of injury Revolver

23. Signature J. L. Williams M.D.

Medical Examiner.

Date signed 9-14-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G 08195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08195

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Roscoe Raymond Hyde

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Elaine A.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

March 23, 1884

8. AGE: Years

Months

Days

If less than one day

59

5

22

hr.

min.

9. Birthplace

Indiana

(Town, county, and state)

10. Usual Occupation

Professor

11. Industry or business

12. Name

John A. Hyde

13. Birthplace

Indiana

14. Maiden Name

Mary Nicholas

15. Birthplace

Indiana

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof 9/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn, Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Baltimore, Md.

19 (a)

SEP 18 1943

Fluorography William

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4101 Parkview Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 15, 1943, at 1:19 PM

21. I certify that death occurred on the date above stated; that I attended

deceased from 8/28 1943 to 9/15 1943.

and that I last saw him alive on 9/15 1943

Immediate cause of death

Coronary occlusion

Duration

Due to

Due to

Other Conditions

CA. TRANSVERSE

colon - resected

(Include pregnancy within 3 months of death)

Date of operation

7/2/43

Major findings of operations

CA. TRANSVERSE

colon - resected.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

While at work?

(e) Means of injury

23. Signature

Thompson

Address

Johns Hopkins Hospital signed 9/15/43

G 08196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08196
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **822 N. Carrollton Ave.**
 (c) Hospital or institution:
N. M. Carroll Home for the Aged
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **822 N. Carrollton Ave.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

ANNIE HARDCASTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10 24

8. AGE:

119

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace **Maryland**

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER12. Name **Not Known**

13. Birthplace

14. Maiden Name **Not Known**

15. Birthplace

16 (a) Informant **Miss Rosa Stewart**(b) Address **822 N. Carrollton Ave.**17 (a) **Burial** (b) Date thereof **9-17-43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn Cem.**Location **Baltimore, Md.**18 (a) Funeral director **Mrs. Frances A. Hemaley**(b) Address **578 W. Biddle St.**19 (a) (b)
(Date rec'd by registrar)**Fluoridation, William, Md.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 15, '43** 19 **43** at **8:30 A**21. I certify that death occurred on the date above stated that I attended deceased from **Sept. 10 19 43** to **Sept. 15 19 43** and that I last saw him alive on **Sept. 14 19 43**

Immediate cause of death

Myocardial Infarction

Duration

4 weeks

Due to

Due to

Other Conditions

Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Ralph W. Beckwith
426 N. G. Lane Date signed **9/17/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 16 1943

Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08197

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution:

So. Balt. Genl Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1616 Elkins Lane

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Evelyn M. Sherbert

3 (b) If veteran, name war

3 (c) Social Security Account No. _____

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1913

8. AGE: Years Months Days If less than one day

6 9 4 hr. min.

9. Birthplace

Balto.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Chas. L. Ad.

13. Birthplace

14. Maiden Name

Ethel K. Phelps

15. Birthplace

Balto

16 (a) Informant

Family

(b) Address

1616 Elkins Lane

17 (a) (Burial, cremation, or removal)

(b) Date thereof 9-16-43

(c) Cemetery or crematory

Green Haven

Location

Kirkland Highway

18 (a) Funeral director

W. L. McClellan

(b) Address

10 E. Fort Ave.

(c) Date rec'd by registrar

Sept 16 1943

(d) Signature

William M. Williams

(e) Date signed

7-15-43

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1943, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1943, to 9-15 1943, and that I last saw her alive on 9-15 1943.

Immediate cause of death

Acute gastro-enteritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Shirley P. [Signature]

Address 1213 Light St Date signed 7-15-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully checked. The UNFADING INK.

G 08198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08198
830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA STS
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 OLIVE ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY TREGOE
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex FEMALE 5. Color or race WHITE 6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife JOHN TREGOE
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) MAY 12 1887
8. AGE: Years 56 Months 4 Days 3 If less than one day hr. min.

9. Birthplace SCRANTON, PA.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name WILLIAM HART DOBBINS
13. Birthplace NEW YORK
MOTHER 14. Maiden Name MARY GAY HART
15. Birthplace SCRANTON, PA.

16 (a) Informant SON - JAMES ALBERT DOBBINS
(b) Address 1808 PATAPSCO ST.

17 (a) B (b) Date thereof 9-18-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Graveside
Location Ritchie Highway

18 (a) Funeral director J. L. McManis
(b) Address 130 E. Fort Ave.

19 SEP 16 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 15 1943 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 10 1943 to SEPT 15 1943, and that I last saw her alive on SEPT 14 1943.

Immediate cause of death CEREBRAL-VASCULAR HEMORRHAGE

Due to HYPERTENSION

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Z. Zangara, M.D.

Address Mercy Hospital Date signed 9/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PRINTED IN PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08199
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

North Broadway

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

22 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind.

(b) County

(c) City or town

Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

619 N. Ellwood Ave

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. Charles C. Marvel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 14, 1889

8. AGE: Years

54

Months

2

Days

0

If less than one day

hr.

min.

9. Birthplace

Delaware

(Town, county, and state)

10. Usual Occupation

Shipbuilder

11. Industry or business

FATHER

12. Name

Henry Collins Marvel

13. Birthplace

Delaware

MOTHER

14. Maiden Name

Ida Henry

15. Birthplace

Delaware

16 (a) Informant

Phnt

(b) Address

as above

17 (a)

Removal

(b) Date thereof

Sept 16/49

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Gold Bellows Ave

Location

Laurel Del

18 (a) Funeral director

Philip Henry Sam

(b) Address

2024 Orleans St

19 (a)

(Date read by)

(b)

Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 14

1943

at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10/43 to 7/18/43

and that I last saw him alive on 7/17/43

Immediate cause of death

Solar Pneumonia

Due to

Type 8 Pneumococcus

Due to

Other Conditions

Bacteremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

none

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. J. H. Jones

Address

Church Home & Hospital

Date signed 9/18/43

SEP 20 1943

G 08200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH08200
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b)

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Date signed

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. 08201

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP 16 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 14, 1943, at 3:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 9/14, 1943.

and that I last saw him alive on 9/14, 1943.

Immediate cause of death

Hypertensive Type Heart Disease

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08202

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **627 W. Mulberry St.**
(c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days) **4**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MD** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **627 W. Mulberry St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Maggie Lawson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Widowed

6 (b) Name of husband or wife

Simon Lawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 5, 1885

8. AGE:

Years

Months

Days

If less than one day

58

6

8

hr.

min.

9. Birthplace **Canden, S.C.**

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name **Thomas Lockwood**

13. Birthplace **S.C.**

14. Maiden Name **Salena ?**

15. Birthplace

16 (a) Informant **Amelia Richardson**

(b) Address **627 W. Mulberry St.**

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **9/16/43**

(month) (day) (year)

(c) Cemetery or crematory **Mt. Calvary**

Location

18 (a) Funeral director **Elroy O. Wilson**

(b) Address **1000 Brantley Ave.**

19

SEP 18 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 15** 19**43**

at **627 W. Mulberry St.**

21. I certify that death occurred on the date above stated and that I last saw **her** alive on **Sept 14** 19**43**

Immediate cause of death

Cerebral Hemorrhage

Duration

15 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

08203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08203

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Santes Baltimore General Hosp

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 916 Burgandy St.
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-10-2087

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 18898. AGE: Years Months Days If less than one day
54 7 4 hr. min.9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

12. Name Don't Know13. Birthplace Russian Poland14. Maiden Name Don't Know15. Birthplace Poland16 (a) Informant Mrs Josephine Solwingelick(b) Address 916 Burgandy St17 (a) Buried (b) Date thereof 9/17/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy CrossLocation Brooklyn18 (a) Funeral director William M Mareck(b) Address 210 1/2 Light St19 SEP 16 1943 (b) Hastington Williams, M.D.
RegistrarMEDICAL CERTIFICATION
Solwingelick (also known as) SAVULICHIK20. DATE OF DEATH September 13 1943 11:40 M21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Cerebral
hemorrhage, spontaneousDue to Arteriosclerotic cardiovascular
diseaseOther Conditions
(Include pregnancy within 3 months of death)22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert E. Graham M.D.
Medical Examiner.Date signed Sept 14 1943

08204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08204
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Date: 1st (b) County

(c) City or town: Baltimore

(d) Street No. 1st - on dump - Phila. R.R. & Penns. R.R.

(e) Citizen of foreign country? (If rural give location)

(f) If yes, name country (Yes or No)

3 (a) FULL NAME

William Koester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Lena Koester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 10 - 1883

8. AGE:

Years

Months

Days

If less than one day

60?

21

28

hr.

min.

9. Birthplace

Balt. Md

10. Usual Occupation

Carpenter

11. Industry or business

FATHER
MOTHER

12. Name

Frank W. Koester

13. Birthplace

Germany

14. Maiden Name

Kate Barr

15. Birthplace

Germany

16 (a) Informant

Lena Koester

(b) Address

704 DeBakey Ave

17 (a)

Burial

(b) Date thereof

Sept. 16/43

(c) Cemetery or crematory

Oak Lawn Cem

Location

Eastern Ave

18 (a) Funeral director

John F. Miller

(b) Address

2334 Jefferson St

SEP 16 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13-1943, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature: Howard J. Wrede M.D.

Date signed 9/13/43

Medical Examiner.

08205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 Registered No. 08205

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1125 Poplar Grove

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Beltsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1125 Poplar Grove

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Michael Joseph Skelly

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

m.

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Elin Beirne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE:

Years Months Days

If less than one day

at 65

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

B & R R

FATHER

12. Name

Lawrence Skelly

13. Birthplace

Ireland

MOTHER

14. Maiden Name

Julia

15. Birthplace

Ireland

16 (a) Informant

Mrs M J Skelly

(b) Address

1125 Poplar Grove

17 (a)

Burial

(b) Date thereof

9/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

old St. Ignace Rd

18 (a) Funeral director

J. J. Foley

(b) Address

1125 Poplar Grove

SEP 16 1943

(Date rec'd by registrar)

H. J. Skelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1943, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 8 1941, to September 1943, and that I last saw him alive on 9-14 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Cerebral Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. J. Skelly

Address 1125 Poplar Grove

Date signed 9/15/43

M. D.

affirmed by Dr. Howard J. Macdonald.

08206
08206
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
910
Registered No. 08206
1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)
3 (a) FULL NAME James Lewis
3 (b) If veteran, name war
3 (c) Social Security Account No. June
4. Sex Male 5. Color of race Col. 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 22, 1905
8. AGE: Years 38 Months 8 Days 21 If less than one day hr. min.
9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Hod - Carner
11. Industry or business
12. Name Henry Lewis
13. Birthplace Alabama
14. Maiden Name Ella Barnes
15. Birthplace Alabama
16 (a) Informant Ella Jones
(b) Address 556 Robert St.
17 (a) Burial (b) Date thereof Sept. 16, 1943
(c) Cemetery or crematory Arbutus Mem. Ch. Location Balto. Co. Md.
18 (a) Funeral director Mrs. George H. Waller
(b) Address 1621 Duin Hill Ave
19 SEP 16 1943 (Date rec'd by registrar) Hunter William M.
20. DATE OF DEATH 9/12/43 19 7:45 A.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 9/9/43 to 9/10/43 and that I last saw him alive on 9/10/43
Immediate cause of death Ventricular Bacteremia
Due to E. coli occ. of this
Due to Gallbladder Infection
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(e) Means of injury
23. Signature J. V. Warkdale M. D.
Address 746 G. Carey St. Date signed 9/14/43

08206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

910

Registered No. 08206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, give town)
(d) Street No. 556 Robert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME James Lewis
3 (b) If veteran, name war
3 (c) Social Security Account No. June

4. Sex Male 5. Color of race Col. 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1905
8. AGE: Years 38 Months 8 Days 21 If less than one day hr. min.
9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Hod - Carner
11. Industry or business

12. Name Henry Lewis
13. Birthplace Alabama
14. Maiden Name Ella Barnes
15. Birthplace Alabama

16 (a) Informant Ella Jones
(b) Address 556 Robert St.
17 (a) Burial (b) Date thereof Sept. 16, 1943
(c) Cemetery or crematory Arbutus Mem. Ch. Location Balto. Co. Md.
18 (a) Funeral director Mrs. George H. Waller
(b) Address 1621 Duin Hill Ave
19 SEP 16 1943 (Date rec'd by registrar) Hunter William M.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/43 19 7:45 A.M.
21. I certify that death occurred on the date above stated, that I attended deceased from 9/9/43 to 9/10/43 and that I last saw him alive on 9/10/43
Immediate cause of death Ventricular Bacteremia
Due to E. coli occ. of this
Due to Gallbladder Infection
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(e) Means of injury
23. Signature J. V. Warkdale M. D.
Address 746 G. Carey St. Date signed 9/14/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

VB 158

PRINTED IN PLAINLY, WITH UNFADING INK. Every item of information should be carefully legible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08207

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Wilkins + Catonsville*
(c) Hospital or institution: *St. Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *55 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *18 S. Franklin Rd.*
(If rural, give location)
(e) Citizen of foreign country *Yes* (Yes or No)
If yes, name country *Ireland*

3 (a) FULL NAME

Mrs. Ellen Mary Gahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Husband - Matthew*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 27, 1871*
8. AGE: Years *72* Months *3* Days *19* If less than one day hr. min.

9. Birthplace *Ireland*
(Town, county, and state)

10. Usual Occupation *house work*

11. Industry or business *at home*

12. Name *Patrick (dec.)*

13. Birthplace *Ireland*

14. Maiden Name *Anna (dec.)*

15. Birthplace *Ireland*

16 (a) Informant *Mr. Matthew J. Gahan*

(b) Address *18 S. Franklin Rd.*

17 (a) *burial* (b) Date thereof *9/18/1942*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Catharine's*
Location *4300 Old Republic Road*

18 (a) Funeral director *John J. Kowalski & Son*

(b) Address *908 W. Hollins St.*

19 (a) *SEP 18 1943* (b) *Huntington Millers, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 15* 1943, at *12:49* M

21. I certify that death occurred on the date above stated; that I attended deceased from *9/12* 1942, to *9/15* 1943, and that I last saw him alive on *9/15* 1942.

Immediate cause of death *Coronary C-V-D*

Due to

Due to

Other Conditions *Pneumonia*
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury *Arthur Rosenberg*

23. Signature *Arthur Rosenberg*

Address *St. Agnes Hosp.* Date signed *9/15/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G 08208
AB-74875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08208
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4240 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1900 Aisquith St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Henry Matthew

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Widower

6 (b) Name of husband or wife Sarah (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-7- (63) ?

8. AGE: Years Months Days If less than one day

61 ?

?

?

hr.

min.

9. Birthplace N.E.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name John Matthew (D)

13. Birthplace N.C.

14. Maiden Name Adeline Houston (D)

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 9 16 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location D. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 412 B. Preston St

19 (a) (b)

(Date rec'd by registrar)

SEP 16 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1943 at 12 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 9/13 1943

and that I last saw him alive on 9/13 1943.

Immediate cause of death Pulmonary
edema

Due to Hypertensive C.V.
disease

Due to

Other Conditions Lentic aortic;
H. Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sargman

Address B C H

Date signed 9/15

Duration
?
?
PHYSICIAN
Underline the
cause to which
death should be
charged statisti-
cally.

G 08209

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08209

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Baltimore(c) City or town Fairfield Camp
(If outside city or town limits, write RURAL and give town)(d) Street No. Trunks B-16
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

THOMAS H. STARNES

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w6 (a) Single, married, widowed, or
divorcedSingle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 19278. AGE: Years Months Days
15 6 19 11 19
hr. min.9. Birthplace Monroe, N. C.
(Town, county, and state)10. Usual Occupation Labor11. Industry or business Ship Yard12. Name Thos. H. Starnes13. Birthplace Monroe, N. C.14. Maiden Name Ruby Stuart15. Birthplace North Carolina16 (a) Informant Mrs Ruby Starnes(b) Address Fairfield Camp17 (a) Burial (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory 9
Location Monroe, North Carolina18 (a) Funeral director Thos. J. Henry(b) Address 1608 Hollins St.19 (a) (b) Huntington Halliwell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1943 at 3:40 AM21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9-17-43 1:45 P. 25/6 M.(b) Where did injury occur? Fairfield, Ind.(c) Did injury occur at home, on farm, industrial place, in public
place? Industrial While at work? Yes(d) Means of injury struck by overhead crane23. Signature W. J. Wallameters M.D.
Assistant Medical Examiner

Date signed

SEP 18 1943

G 08210

AB-29345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08210
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs. 8 Mos. 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore Hotel-Camden St.

(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME

Ernest Hill

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26-1874

8. AGE: Years Months Days If less than one day

69

1

10

hr.

min.

9. Birthplace England

(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

12. Name Thomas Hill (D)

13. Birthplace England

14. Maiden Name Elizabeth Roberts (D)

15. Birthplace England

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 16 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 16 1943 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1943. at 7:10 P.M.

21. I certify that death occurred on the date above stated, that I attend-
ed deceased from 7/1 1943, to 9/6 1943
and that I last saw him alive on 9/6 1943.

Immediate cause of death

Undetermined
HemiparesisDue to primary retention;
myeloid stenosisDues to H.S. S.K. Disease
Sensitivity & debility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Anat. Board

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sengman

Address 13 CH

Date signed 9/15

M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G 08211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **Baby Girl Mills**
3 (b) If veteran, name war No. 3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **Black** 6 (a) Single, married, widowed, or divorced. **Single**
6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)
8. AGE: Years Months Days If less than one day
24 hr. min.

9. Birthplace **Md.** (Town, county and state)
10. Usual Occupation **Child**
11. Industry or business

MOTHER 12. Name **Henry Mills**
13. Birthplace
14. Maiden Name **Mary**
15. Birthplace

16 (a) Informant
(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location **JOHN HOPKINS MEDICAL SCHOOL SEP 16 1943**

18 (a) Funeral director **Commissioner of Health**
(b) Address
19 **SEP 16 1943** **Huntington Williams, M.D.** Registrar

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md.** (b) County
(c) City or town **Baltimore** (If outside city or town limits, write RURAL and give town)
(d) Street No. **721 Rutland** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH **August 27 1943** at **4:30** PM
21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 27 1943** to **Aug 27 1943**, and that I last saw her alive on **8.27 1943**.
Immediate cause of death **Cerebral hemorrhage today**
Due to **Trauma (birth)**
Due to **Asphyxia**
Other Conditions **Prematurity**
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature **C. Lee Randle**
Address **Johns Hopkins Hosp** Date signed **8/28**

PHYSICIAN
Underline the cause to which death should be charged statistically.

08212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08212

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days) 1 day

(e) Length of stay in Baltimore (yrs., mo., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State, Maryland (b) County

(c) City or town, Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 8 N. Stricker Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1943

8. AGE: Years Months Days If less than one day
1 hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name John Berry

13. Birthplace Washington, D.C.

14. Maiden Name Violet Sullivan

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address Johns Hopkins Hospital

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL SEP 16 1943

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 16 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VB 150

0369

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 19 43. at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 19 43. to Aug. 31 19 43. and that I last saw him alive on Aug. 31 19 43.

Immediate cause of death Prematurity
Atalectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Johns Hopkins Hospital Date signed 9-2-43

M. D.

08213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08213

Registered No.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1602 E. Pratt
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Marie Barbour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-43

8. AGE: Years Months Days If less than one day

114

hr.

min.

9. Birthplace md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Samuel Barbour13. Birthplace Va.14. Maiden Name Charlotte Parker15. Birthplace Va.16 (a) Informant Records(b) Address JOHNS HOPKINS HOSPITAL17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL SEP 16 194318 (a) Funeral director Commissioner of Health

(b) Address

SEP 16 1943 (b) Huntington Williams, M.D.
Date signed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1943 at 9¹⁵ AM21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1943 to Aug. 29 1943 and that I last saw her alive on Aug. 29 1943

Immediate cause of death

Congenital Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Kaye
Address John Hopkins Date signed 8/31/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Give the cause of death clearly and legibly.

08214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9

G 08214
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd., + Herring Run.
(c) Hospital or institution Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 McHenry St
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME Emil Johnson
3 (b) If veteran, name war 3 (c) Social Security Account No.
4 Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 27, 1943
8. AGE: Years 2 Months 15 Days 16 If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

12. Name Andrew O. Johnson
13. Birthplace Balto Md
14. Maiden Name Eva E. Murrich
15. Birthplace Balto Md

16 (a) Informant Andrew O. Johnson
(b) Address 1322 McHenry St
17 (a) Burial (b) Date thereof 7-16-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fondox Park
Location Balto
18 (a) Funeral director Frederick A. [unclear]
(b) Address 1400 W Lombard St
19 (a) (b) Huntington

20. DATE OF DEATH September 13, 1943, at 2⁵² P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13, 1942, to Sept 13, 1942, and that I last saw h.c.e. alive on Sept. 13, 1943.
Immediate cause of death Respiratory failure
Due to Pertussis, bronchopneumonia
Due to hospital
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature Margaret Smith M.D.
Address Sydenham Hospital Date signed 9/12/43

SEP 16 1943

G 08215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08215

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 125 S. Arlington Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 125 S. Arlington Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Leon L. Stack

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Ida J. Stack6 (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) March 6, 1883

8. AGE: Years Months Days If less than one day

6068

hr.

min.

9. Birthplace Caroline Co. Md.

(Town, county, and state)

10. Usual Occupation Chipper11. Industry or business Copper Co.12. Name Frederick Stack13. Birthplace Caroline Co. Md.14. Maiden Name Mary A. Nichols15. Birthplace Md.16 (a) Informant Mrs Ida J. Stack(b) Address 125 S. Arlington Ave.17 (a) Burial (b) Date thereof Sept. 18, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MeadowridgeLocation Washington Blvd.18 (a) Funeral director Frederick & Co.(b) Address 125 S. Arlington Ave.19 (a) Frederick & Co.

(Date rec'd by registrar)

SEP 18 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14th 1943, 3 A. M.21. I certify that death occurred on the date above stated; that I attended deceased from July 30, 1943 to Sept 14, 1943 and that I last saw him alive on Sept 13, 1943.Immediate cause of death Myocardial Infarction
Coronary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frederick & Co.Address 2151 W. 11th St. Date signed 9/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

440953 G 08216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08216

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State S. CAR (b) County

(c) City or town CLINTON

(If outside city or town limits, write RURAL and give town)

(d) Street No. 25 Sloane St.

(If rural, give location)

(e) Citizen of foreign country? NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

EDWARD A HILL

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-25-76

8. AGE:

Years

Months

Days

If less than one day

67

2

21

hr.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual Occupation

SUPERINTENDENT

11. Industry or business

Cotton Mill

FATHER

12. Name

William Sparten Hill

13. Birthplace

N.C.

MOTHER

14. Maiden Name

Polly Ann Davis

15. Birthplace

S.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) SHIPMENT

(b) Date thereof

9/16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

WELFORD - WELFORD S.C.

Location via CLINTON S.C.

18 (a) Funeral director

Chas. H. Evans, Son & Co.

(b) Address

712 N. Mt. Royal Ave

19 (a)

(b)

(Date rec'd by registrar)

SEP 16 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1943. at 7:06 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1943, to Sept 15 1943, and that I last saw him alive on Sept 15 1943.

Immediate cause of death operation (nephrotomy)

Due to Hemorrhage & Shock

Due to

Other Conditions Cong. Absence of left kidney

(Include pregnancy within month of death)

Date of operation 9/15/43

Major findings of operations: Multiple calculi in only kidney

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James A. Singiser

Address J. H. Hospital

Date signed

9/16/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08217

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-4, 1936

8. AGE: Years Months Days If less than one day

6

8/10

12

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept 19, 1943 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) by registrar

SEP 16 1943

VS 158

Flushing, Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/16

19 43 at 9⁰⁰ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1943 to 9/16 1943.

and that I last saw him alive on 19

Immediate cause of death

Acute Rheumatic Fever with Pericarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address University Heights Date signed 9/16/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08218
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33 rd & Colver St

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 1/2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

Indefinite

3 (a) FULL NAME

LAWRENCE WEIS

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-03-5125

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 10, 1892

8. AGE:

Years

Months

Days

If less than one day

50

11

4

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Salesman - May 6.

11. Industry or business

Toy & Luggage

FATHER

12. Name

Mr. Jacob Weir

13. Birthplace

Balt. Ind

MOTHER

14. Maiden Name

Berrie Stuckel

15. Birthplace

Balt. Ind

16 (a) Informant

Mrs. M. Weis

(b) Address

817 Chauncy Ave

17 (a) Burial

(b) Date thereof 9/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak & Shalom

Location

Balt. Md.

18 (a) Funeral director

David Bonheim & Son

(b) Address

1902 Eutaw Place

SEP 16 1943

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

817 Chauncy Ave

(If rural give location)

(e) Citizen of foreign country?

No.

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 17

1943, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 13, 1943, to Sept 17, 1943.

and that I last saw h/m alive on Sept 17, 1943.

Immediate cause of death

Cardiac failure

Due to

Rheumatic Heart Disease

Duration

3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John A. Nesbitt, Jr.

M. D.

Address

Union Mem. Hosp. Date signed 9-17-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 08219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08219

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6111 Gist Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6111 Gist Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

SARAH B. ABRAMSON.

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Married

6 (b) Name of husband or wife Hyman Abramson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1882.

8. AGE:

Years

Months

Days

If less than one day

60

9

10

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife.

11. Industry or business

FATHER

12. Name Isaac Berman,

13. Birthplace

Russia.

MOTHER

14. Maiden Name Lena Wagenheim,

15. Birthplace

Russia.

16 (a) Informant Mr. Hyman Abramson,

(b) Address 6111 Gist Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/19/43.

(month) (day) (year)

(c) Cemetery or crematory Har Sinai

Location Balto. Md.

18 (a) Funeral director Sarah Bonasheim

(b) Address 1902 Eutaw Place.

19 (a)

SEP 16 1943

(Date rec'd by registrar)

William Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14th. 1943. at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1942 to Sept. 14, 1943. and that I last saw her alive on Sept. 13, 1943.

Immediate cause of death 1) Intestinal obstruction. 2) - Nephritis. 3) - Osteo-arthritis 4) Cardiac failure

Due to

Due to

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Malcolm H. Spry

Address 2351 Eutaw Place. Date signed 9/18/43

Duration

Underside for past 12 years.

Last other for past 6 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08220

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 240 S. Eden St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WASIL

KIRILO WICH

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or
divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Not known?8. AGE: Years Months Days If less than one day
about 50? hr. min.

9. Birthplace

Russian

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Not known

13. Birthplace

Russian

14. Maiden Name

Not known

15. Birthplace

Russian

16 (a) Informant

Mr. Frank Kardash

(b) Address

2127 E. Pratt St.

17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof Sept 17, 1943
(month) (day) (year)

(c) Cemetery or crematorium

Holy Trinity Russian

18 (a) Funeral director

John G. Greblancher, Jr.

(b) Address

923 S. Paca St.

SEP 16 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1943 at 2:40 M21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage

Due to

Enterorrheum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

Means of injury

23. Signature H. Z. Wallenweber M.D.Date signed 9-15-43

The cause of death must be written clearly and legibly. The cause of death must be written clearly and legibly.

G 08221

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 08221
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

Street address

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 15 South Exeter Street

(If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Australia

3 (a) FULL NAME

HERMAN ADLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of ~~husband~~ or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE: Years

65

Months

Days

If less than one day

hr. min.

9. Birthplace Australia

(Town, county, and state)

10. Usual Occupation Retired barber

11. Industry or business

FATHER
MOTHER

12. Name Mendel Adler

13. Birthplace Australia

14. Maiden Name Shirley

15. Birthplace Australia

16 (a) Informant Dept. Records

(b) Address

17 (a) Burial (b) Date thereof 9-17-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location German Hill Rd.

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1427 E. Baltimore St.

SEP 17 1943 (Detected by) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1943 at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Isotric Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Maldeis M.D.

Date signed 9-16-43

08222

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08222
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 day

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2034 Main St and St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
F5. Color or race
W6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife Milton Woods

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 58 Months Days If less than one day
hr. min.9. Birthplace N Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

12. Name Ringge

13. Birthplace New York

14. Maiden Name Bout / Keon

15. Birthplace

16 (a) Informant Milton R. Wood

(b) Address 2034 Main St

17 (a) Burial (b) Date thereof Sept. 18-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium New Cathedral

Location Edmondson Ave

18 (a) Funeral director Edward L. L. L.

19 (a) SEP 17 1943 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1943, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-1 1942, to 9-15 1943,
and that I last saw her alive on 9-15 1943.Immediate cause of death: Cancer
Duration

Due to Cancer

Due to Cancer

Other Conditions Kidney stones

(Include pregnancy within 3 months of death)

Date of operation 9-1-43

Major findings of operations: Cancer

obstruction & gangrene

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. L. L.

Address U of Md. Hosp

Date signed 9-15-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08223

SLACUM
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V
126

G 08223
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

3 (a) FULL NAME

Mrs. Margaret Slacum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Howard Slacum

7. Birth date of deceased (mo., day, yr.)

March 23, 1874

8. AGE:

Years

Months

Days

If less than one day

69

0

24

hr.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Own home

12. Name

James H. Hurley

13. Birthplace

Maryland

14. Maiden Name

Jane Hurley

15. Birthplace

Maryland

16 (a) Informant

Mrs. Howard Slacum

(b) Address

203 Chaptank Ave Cambridge Md

17 (a)

Burial

(b) Date thereof

Sept 19, 1943

(c) Cemetery or crematory

Cambridge

(d) Location

Cambridge Md

18 (a) Funeral director

John O. Mitchell & Son

(b) Address

1900 E. Bay View Ave

(c) City

Baltimore

(d) State

Md

(e) Signature

William H. Williams

(f) Title

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Dorchester

(c) City or town

Cambridge

Md.

(d) Street No.

303 Chaptank Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1943, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3, 1943, to Sept 16, 1943, and that I last saw her alive on Sept 16, 1943.

Immediate cause of death

Hepatic insufficiency

Due to common duct stone

i jaundice

Due to

Other Conditions Anterior splenic
cardio-vascular disease.

(Include pregnancy within 8 months of death)

Date of operation 9-7-43

Major findings of operations Common

duct stone cholelithiasis

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Isabella Harrison

Address

Church Home & Hospital

Date signed

9-16-43

SEP 17 1943

VS 100

08224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08224

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1300 Levertown Ave
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) File No. 1300 Levertown Ave
(If rural give location)
(e) Citizen of foreign country? 3300 (Yes or No)
If yes, name country

3 (a) FULL NAME

SadieGabler

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Martin Gabler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 2 - 1881

8. AGE: Years Months Days If less than one day

61914

hr. min.

9. Birthplace Baltimore
(Town, county, and state)10. Usual Occupation at home

11. Industry or business

12. Name William George13. Birthplace Baltimore14. Maiden Name Elizabeth Lucas15. Birthplace Baltimore16 (a) Informant Wm George(b) Address 3300 Levertown Ave17 (a) Burial (b) Date thereof Sept 20
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Oak Lawn CemLocation Rural18 (a) Funeral director Ulrich Funeral Home(b) Address 2004 S. Delaware St19 (a) SEP 17 1943 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1943 at 8 25 AM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Chronic myocardial
degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.Date signed Sept. 16 1943

08225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08225

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address:

(c) Hospital or institution:

Baltimore City Hosp. 1-1-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3105 Elliott St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

4

hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Earle Thulle

13. Birthplace Baltimore, Md.

14. Maiden Name Josephine Kolmowski

15. Birthplace Baltimore, Md.

16 (a) Informant Mary Kolmowski

(b) Address 3212 Elliott St

17 (a) X (b) Date thereof 9-17-73 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment St Stanislaus Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson St

SEP 17 1943 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1943 at 12:20 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 16 1943 12:20 PM

(b) Where did injury occur? Elliott St & Ellwood Ave

(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? No

(d) Means of injury Pedestrian struck by truck

23. Signature Robert E. Graham M.D.

Date signed Sept. 16 1943

G 08226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08226

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

BALTIMORE, MD.

(Town, county, and state)

10. Usual Occupation

MANAGE-FEEDER

11. Industry or business

KIMBLE-LAUNDRY

MOTHER
FATHER

12. Name

ALFRED-SMITH

13. Birthplace

BILKTON-MP

14. Maiden Name

ANNIE-MARCUS

15. Birthplace

BILKTON-MD.

16 (a) Informant

LARRY SMITH

(b) Address

538 S. BENTLEY ST.

17 (a)

BURIAL

(b) Date thereof

9/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

HUNTER-PARK

Location

Baltimore, Md.

18 (a) Funeral director

F. B. WIPPERT, SON

(b) Address

1300 EUTAWY-PRAGE

19

SEP 17 1943

(b) Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 14 1943 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

08227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08227
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-1940

8. AGE: Years 3 Months 7 Days 19 hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Harry S. Blair

13. Birthplace Baltimore, Md.

14. Maiden Name Eleanor Chewning

15. Birthplace Lancaster Co., Va.

16 (a) Informant Harry S. Blair

(b) Address 548 Mc Meekin St

17 (a) Burial (b) Date thereof Sept. 17, 1943

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Volled

(b) Address 1631 W. 1st St.

19 SEP 17 1943

20. DATE OF DEATH Sept 10, 1943, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Sept 10, 1943, and that I last saw him alive on Sept 15, 1943.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 548 Mc Meekin St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1943, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Sept 10, 1943, and that I last saw him alive on Sept 15, 1943.

Immediate cause of death

Tuberculous Osteitis
(Generalized)

Due to

Disease Secondary Anemia

Other Conditions Pulmonary TB
(Childhood type)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature G. H. Bayfield

Address Providence Hospital Date signed 9-16-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

8228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08228
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1815 Etting St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. *None*

4 Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 11, 1872

8. AGE: Years Months Days

*70 7/11**-11**-3*

If less than one day

hr. min.

9. Birthplace

Harford Co., Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *Francis Matthews*(b) Address *1607 Madison Ave.*17 (a) *Burial* (b) Date thereof *Sept. 17, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

*Int. Auburn*Location *Baltimore, Md.*18 (a) Funeral director *Rev. George H. Holland*(b) Address *1631 Druid Hill Ave.*19 (a) *SEP 17 1943* (b) *Dr. H. P. ...*20 (a) *SEP 17 1943* (b) *Dr. H. P. ...*

VS 114

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write R.U.M. and give town)

(d) Street No.

1815 Etting St.

(If rural, give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 14* 19*43* at *10:30* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 7* 19*43*, to *Sept 14* 19*43*, and that I last saw him alive on *Sept 14* 19*43*.

Immediate cause of death

*Myocardial failure*Due to *Hypertrophy and dilataction of heart*Due to *Enlarged liver*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Dr. H. P. ...

Address

1632 Druid Hill Ave.

Date signed

M. D.

9-17-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08229
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

14 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 16 1943, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1943, to Sept 16 1943, and that I last saw him alive on Sept 16 1943.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 8230
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 719 S. Montford Ave

(c) Hospital or institution:

Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 719 S. Montford Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Helen Tyma

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1877

8. AGE: Years Months Days If less than one day

66

4

-

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name ? Schuder

13. Birthplace Poland

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Bertha White (Daughter)

(b) Address 719 S. Montford Ave

17 (a) Burial (b) Date thereof 9-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore, Md.

18 (a) Funeral director George A. Weber

(b) Address 705 South Ann Street

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16th 1943 at 2:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1943 to Sept 6 1943. and that I last saw her alive on Sept 6 1943.

Immediate cause of death

Coronary of Stomach

5/17/43

Due to

Due to Cordiac for ages

9/15/43

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 301 E. Kentwood Date signed 9/16/43

08231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08231

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **307 W. Biddle St.**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

3 (a) FULL NAME

Eva Hunter3 (b) If veteran, name war
No3 (c) Social Security Account
No. None

4. Sex **F** 5. Color or race **C** 6 (a) Single, married, widowed, pg
 divorced. **Separated**

6 (b) Name of husband or wife **James**
 6 (c) If alive, give age **42** years

7. Birth date of deceased (mo., day, yr.) **9/17/1901**

8. AGE: Years **41** Months **11** Days **28** If less than one day
 hr. min.

9. Birthplace **Baltimore, Md.**
 (Town, county, and state)

10. Usual Occupation **Domestic**

11. Industry or business

12. Name **Wm. Carter**13. Birthplace **Baltimore, Md.**14. Maiden Name **Lena Bohman**15. Birthplace **Baltimore, Md.**16 (a) Informant **Edward Carter (Brother)**(b) Address **1224 Madison Ave**

17 (a) **Burial** (b) Date thereof **9/18/43**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn Cem.**
 Location **Baltimore, Md.**

18 (a) Funeral director **Charles G. Cooper**(b) Address **514 N. Calhoun St.**

SEP 17 1943

(Date rec'd by Registrar) **Huntington Williams, M.D.**

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **307 W. Biddle St.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 15 1943 at 5:55 P**

21. I certify that death occurred on the date above stated; that I attend-
 ed deceased from **Sept 10 1943** to **Sept 15 1943**
 and that I last saw her alive on **Sept 15 1943**

Immediate cause of death

Lobar Pneumonia 5 days
 Due to

Due to

Other Conditions **None**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence at **M**
 (c) Where did injury occur?
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public
 place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature **Nick Petter** M. D.
 Address **817 H. Hamilton** Date signed

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

08232

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08232
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 577 Baker Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JESSE MOSES CRAGGETT

3 (b) If veteran, name war
World's War3 (c) Social Security Account
No.4. Sex
Male5. Color or race
Col.6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Louanna Craggett
(Moore)-Single name

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) May 21, 1886

8. AGE: Years Months Days If less than one day
58 3 24 23 hr. min.

9. Birthplace Martinville, Va.

10. Usual Occupation Burner-Md. Dry Dock (3 mos. ago)

11. Industry or business

12. Name Tobe Craggett

13. Birthplace Martinville, Va.

14. Maiden Name Mathilda ?

15. Birthplace Martinville, Va.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto. National
Location Md.

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Oruid Hill Ave

19 (a) SEP 17 1943 (b) Huntington Williams, M.D.

VB 180

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 14, 1943, at 8:45 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 24, 1943, to Sept. 14, 1943,
and that I last saw him alive on Sept. 14, 1943.

Immediate cause of death

Multiple myeloma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 9/18/43

Duration
Unknown

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Va-13608

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08233

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3821 Garrison Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 3821 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph H. Illsley (Joseph Howard Illsley)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife Mary M. Illsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/1875

8. AGE: Years Months Days If less than one day

671120

hr.

min.

9. Birthplace Georgetown, Mass.

(town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER

12. Name unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Dorothy Newcomb(b) Address 33 Columbia Ave., Vineland, N.J.17 (a) Cremation (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon Park Crematory
Location Baltimore, Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Baltimore, Md.19 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1943, 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. Tickally, M.D.
Medical Examiner.Date signed 9/18/43

08234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH08234
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 852 Rhinchar
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Myrtle Anderson

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 19438. AGE: Years Months Days If less than one day
6 19 hr. min.9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Anderson13. Birthplace Norfolk Va14. Maiden Name Pyola Lunford15. Birthplace Norfolk Va.16 (a) Informant William Anderson(b) Address 852 Rhinchar St17 (a) Burial (b) Date thereof Sept. 17, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory W. Auburn Cem.

Location

18 (a) Funeral director Mrs. Kate P. Williams(b) Address 322 W. Lombard St.19 SEP 17 1943 (b) Washington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1943 at 8:12 A.M.21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Infantile Diarrhoea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature B. B. Williams, M.D. Medical Examiner.Date signed 9/16/43

G 08235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08235

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1406 E Preston St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9 NO

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Maria Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 21, 1867

8. AGE:

76

Years

Months

7

Days

13

If less than one day

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Abraham Artie

13. Birthplace

Va.

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Abraham Baker

(b) Address

1406 E. Preston St.

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 17/43

(c) Cemetery or crematory

Int. Calvary Cemo.

Location

A. A. County

18 (a) Funeral director

Mrs. Robert A. Ellis & Dgt.

(b) Address

129 N. Caroline St.

19

SEP 17 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1406 E Preston St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1943

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 1936 to SEPT. 14, 1943

and that I last saw her alive on SEPT. 13, 1943

Immediate cause of death

Duration

CHRONIC MYOCARDITIS 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Francis B. Lutz

Address

1501 E. Eager St

Date signed 9/17/43

M. D.

PLEASE WRITE PLAINLY, and in plain ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

08236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08236

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1202 N. Ellwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 1202 N. Ellwood Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP 17 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16-1943 at M

21. I certify that death occurred on the date above stated; that I attended
deceased from Aug 1 1943 to Sept 16 1943
that I last saw her alive on Sept 16 1943

Immediate cause of death

Arteriosclerotic Cardio
vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1212 N. Patterson Ave M.D.
Date signed 9/17/43

Duration

6 months

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

08407832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08237
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

DR. JOHN L DORSEY

3 (b) If veteran, name was

World War II

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Gertrude

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.)

12-14-93

8. AGE:

Years

Months

Days

If less than one day

49

9

1

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Physician

11. Industry or business

FATHER
MOTHER

12. Name

John R Dorsey

13. Birthplace

Md

14. Maiden Name

Lillian Hooper

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Sept 17/43

(c) Cemetery

Cypress Hill

Location

18 (a) Funeral director

John A. Mitchell

(b) Address

1900 Putnam Place

(Date of death)

SEP 27 1943

(b) Registrar

Frank J. Otterbach

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1015 St George's Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 15

1943

at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1943, Sept 15 1943, and that I last saw him alive on Sept 15 1943.

Immediate cause of death

Brain tumor - glioma - malignant

Duration

9.2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

9-11-43

Major findings of operation:

Benign

Thrombosis

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Frank J. Otterbach

Address

J. H. H.

Date signed 9-25-43

238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08238
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *516 Carlington Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edward P. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 26, 1874*

8. AGE:

Years

Months

Days

*59**4**20*

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 17 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept 16*19 *43*, at

M

21. I certify that death occurred on the date above stated; that I attended deceased from *4-28 1943* to *9-15 1943* and that I last saw h/m alive on *9-15 1943*.

Immediate cause of death

*CORONARY ARTERY DISEASE**Hypertensive Cardio-vascular dis-*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address *5217 York Rd*Date signed *9/16/43*

Duration

2 YRS 3

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08239

Registered No.

441171

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1431 Jefferson St.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Lizzie Murray

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

20 Aug. 8, 1890

8. AGE:

Years

Months

Days

If less than one day

*53**1**46*

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Harry Murray

13. Birthplace

MOTHER

14. Maiden Name

Georganna Smith

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Buried

(b) Date thereof

9/17/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

West Calvary

Location

18 (a) Funeral director

Elroy Wilson

(b) Address

1000 Broadway Ave

SEP 17 1943

Huntington Williams

VB 124

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 14, 1943, 8 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 13, 1943* to *Sept 14, 1943* and that I last saw *her* alive on *Sept 14, 1943*

Immediate cause of death

Respiratory Failure

Due to

Aemia

Due to

*? Carcinoma**? site*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John H. H. H. H.

Address

John H. H. H. H.

Date signed

9/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2909 Halcyon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2909 Halcyon Ave
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Paul Waldhauser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife Naomi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 49 Months 2 Days 25 If less than one day hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Date

(Date rec'd by registrar)

VB 124

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1943 at 3:05 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1943 to Sept 16 1943, and that I last saw him alive on Sept 16 1943.

Immediate cause of death

Bronchogenic Carcinoma of Lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

W. D.

08241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08241

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Wilkins & Cator Aves.*
 (c) Hospital or institution: *St. Agnes Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *434 S. Patterson Pk. Ave.*
 (If rural give location)
 (e) Citizen of foreign country? *No.* (Yes or No)
 If yes, name country

3 (a) FULL NAME

Michael G. Downs

3 (b) If veteran, name war

3 (c) Social Security Account
No. *22059500*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Wife - Mary Carey

6 (c) If alive, give age

9-8-64

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years *79* Months *7* Days *7* If less than one day
hr. min.9. Birthplace *Baltimore - Md.*

(Town, county, and state)

10. Usual Occupation

Retired Restaurant

11. Industry or business

FATHER
MOTHER

12. Name

John (dec.)

13. Birthplace

Ireland

14. Maiden Name

Mary Murray

15. Birthplace

Ireland

16 (a) Informant

Murray House

(b) Address

*434 S. Patterson Park Ave.*17 (a) *Burial*(b) Date thereof *Sept 18-43*

(c) Cemetery or crematory

New Cathedral

Location

Belair Road

18 (a) Funeral director

Frank V. Pipitone

(b) Address

2818 E. Baltimore St.

SEP 17 1943

(c) Date of death

Sept 18 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 15, 1943, 2:50 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *9-14 1943* to *9-15 1943*, and that I last saw him alive on *9-15 1943*.

Immediate cause of death

Arteriosclerotic C-V

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *C. Arthur Korsch*Address *St. Agnes Hosp.* Date signed *9/18/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08242

T.N

76581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08242

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2424 W. Baltimore St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Vincent Bardonaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15th, 1911

8. AGE: Years Months Days If less than one day

32

6

1

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

12. Name Laurence Bardonaro

13. Birthplace Italy

14. Maiden Name Josephine Messina

15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Sep 20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director F.V. Sipitone

(b) Address 2818 E. Baltimore St

19 (a) (b)

(Date rec'd by registrar)

Registrar

VB 150

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1943 at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/16 1943 and that I last saw him alive on 9/16 1943.

Immediate cause of death

Pulmonary T.B.C., etc.

Duration

1 yr.

Due to

Due to

Other Conditions

Emphysema, etc.

6 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

E. L. Surgen

Address

13 CH

Date signed 9/17

08243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08243

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE:

Years

Months

Days

If less than one day

52

hr.

min.

9. Birthplace

(Town, county, and state)
Unknown

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral Director

(b) Address

19

SEP 17 1943

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7,

1943, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due

to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

6/7/43

at

2:30 P.

M.

(b) Where did injury occur

1623

Lancaster St.

(c) Did injury occur at home, on farm, industrial place, in public

place? home

While at work? no

(d) Means of injury

suicide by hanging

23. Signature

Robert Lee Graham

M.D.

Date signed

Aug 24 1943

G 08244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08244

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Howard & Madison*
- (c) Hospital or institution:
Mr. Gen. Hook
- (d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2*
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *Anne Arundel*
- (c) City or town *Harmans, Md.*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. (If rural give location)
- (e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Rev. John B. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*M*6 (b) Name of husband or wife *Margaret*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 17, 1886

8. AGE:

Years

Months

Days

If less than one day

*57**6**28*

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Minister

11. Industry or business

FATHER

12. Name

Alfred T. Hopkins

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Virginia Beatty

15. Birthplace

Baltimore

16 (a) Informant

Margaret Hopkins

(b) Address

Harmans Md.

17 (a)

Burial

(b) Date thereof

9/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Friendship

Location

Campy meade Rd.

18 (a) Funeral director

Clarence F. Hoffman

(b) Address

1639 N. Broadway

SEP 17 1943

V8 120

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 14 1943 at 11:10 A

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 12 1943* to *Sept 14 1943*, and that I last saw him alive on *Sept 14 1943*.

Immediate cause of death

1. Cerebral hemorrhage with right hemiplegia

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at *M*
- (c) Where did injury occur?
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
- (e) Means of injury
23. Signature *G. Herman Williams* M. D.
- Address *Md. Gen. Hook* Date signed *Sept. 14, 1943*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08245

BALTIMORE CITY HEALTH DEPARTMENT

G 08245

T.N

27270

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4040 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1413 N. Washington St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Morrison Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

Married

6 (b) Name of husband or wife Anna (Sep.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb, 7th, 1880

8. AGE:

Years

Months

Days

If less than one day

63

7

9

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George Schmidt

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4040 Eastern Ave (Records)

17 (a) Burial

(b) Date thereof 9/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

E. North Ave

18 (a) Funeral director Laurence F. Hoffman

(b) Address 1639 N. Broadway

Huntington Hillman M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 1943 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1937 to 9-16 1943, and that I last saw him alive on 9-16 1943.

Immediate cause of death

Pneumonia

Duration

10 days

Due to

Due to

Other Conditions Pulmonary TB

6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Hest

Address B. C. R.

Date signed 9/18/43

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

SEP 17 1943

VB 100

G 08246

BALTIMORE CITY HEALTH DEPARTMENT

G 08246

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 338 51

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State N.Y. (b) County

(c) City or town EAST ORANGE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 45 No. Walnut St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George Washington Harris

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife Margaret L. Rigg Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1858

8. AGE: Years Months Days If less than one day

85

0

1

hr.

min.

9. Birthplace Old Mystic, Connecticut

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business Dept. Agriculture, Wash. D.C.

12. Name William C. Harris

13. Birthplace Hannibal Missouri

14. Maiden Name Elizabeth Comer

15. Birthplace New Jersey

16 (a) Informant Geo. P. Harris (Son)

(b) Address 3940 Cloverhill Road, City

17 (a) Burial (b) Date thereof 9-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Elm Grove

Location Mystic, Conn.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Avenue, City

SEP 17 1943

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1943 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1943 to Sept 17 1943.

and that I last saw him alive on Sept. 16 1943.

Immediate cause of death

BRONCHO-PNEUMONIA

(Terminal)

Due to intestinal

obstruction

Due to old post-operative

hernia

Other Conditions senility;

auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Herbst, Jr.

Address Union Memorial Hospital Date signed 9-17-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08247

Registered No. _____

1. PLACE OF DEATH: Union Memorial Hospital
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) Curacao, Dutch West Indies
(b) County _____
(c) City or town Curacao, Dutch West Indies
(If outside city or town limits, write RURAL and give town)
(d) Street No. _____
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Holland

3 (a) FULL NAME Gerhard van Wazal
3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____
4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife _____ 6 (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Feb. 10 1942
8. AGE: Years 1 Months 7 Days 6 If less than one day _____ hr. _____ min.
9. Birthplace Curacao, Dutch West Indies
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business _____

FATHER
12. Name Myndert van Wazal
13. Birthplace Amsterdam, Holland
MOTHER
14. Maiden Name Johanna Cornelia van Buren
15. Birthplace Amsterdam, Holland

16 (a) Informant Medical chart
(b) Address Union Memorial Hospital
17 (a) Burial (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Park
Location Towson, Maryland
18 (a) Funeral director Stewart & Mowen Company
(b) Address 102-24 North Avenue, City

19 (a) 17 1943
(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1943 at 5:25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1943 to Sept. 16 1943, and that I last saw him alive on Sept. 16 1943.

Immediate cause of death
Respiratory Failure

Due to Hypertrophy

Due to Unknown

Other Conditions Following repair of cleft palate
(Include pregnancy within 3 months of death)

Date of operation Sept. 15, 1943

Major findings of operations: Cleft Palate

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____
23. Signature George L. Huntington Jr. M. D.
Address 332 E. University Pkwy. Date signed 9-17-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08248

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Community Hospital*(c) Hospital or institution: *4*(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 mo*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md*(b) County *Harford*(c) City or town *Forest Hill*

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME *Mrs Clara Warner*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female*5. Color or race *white*6 (a) Single, married, widowed, or divorced *Widow*6 (b) Name of husband or wife *Silas Warner*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Apr 11 1875*

8. AGE:

Years *68*Months *5*Days *6*

If less than one day

hr.

min.

9. Birthplace *Forest Hill Harford Co md*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *John Kean*13. Birthplace *Harford Co md*14. Maiden Name *Cornelia Bryant*15. Birthplace *Elmira N.Y.*16 (a) Informant *Mrs Harvey Walker*(b) Address *Forest Hill md*17 (a) *Burial*(b) Date thereof *Sept 17-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Centre*Location *Forest Hill md*18 (a) Funeral director *Walter G. Smith*(b) Address *Jam Hillville md*

19 1943

Date rec'd by registrar

Registrar *William H. Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/17/1943*at *2:30 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *8/19/1943* to *9/17/1943* and that I last saw him alive on *9/17/1943*Immediate cause of death *Pulmonary**Edema*

Duration

Due to *Metastatic Carcinoma**of lung (md)*

Due to

Other Conditions *Chronic Cholelithiasis**Splenic tumor*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy *Metastatic C2 lung*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *L. D. J. Smith M.D.*Address *Union, Harp.*Date signed *9/17/43**Redwood & Greene Sts
Baltimore md.*

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08249

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 17 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16 - 1943, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1943, to Sept 16 1943 and that I last saw him alive on Sept 16 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 6 months of death)

Date of operation July 1943.

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/16/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08250

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account
No. 215-09-7740

Sex

Male

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Dora Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

Less than one day

41

-

26

hr.

min.

9. Birthplace

Church-Land Va.

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

Baltimore

1411 Mulliken Court

No

Sept 16, 1943

4:30 p.m.

I certify that death occurred on the date above stated; that I attended deceased from Sept 19 to 19

and that I last saw h/ alive on 19

Immediate cause of death

Diabetes Mellitus

Due to

D.O.A.

Due to

Other Conditions

Diabetic Coma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Sept 17, 1943

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08251

CLATBORNE
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08251

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1125 Port St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1125 Port St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME James E. Clontone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male
col5. Color or race
col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jane Calaboun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

70 1872

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edwin Calaboun

13. Birthplace Carlin Co Va

14. Maiden Name unknown

15. Birthplace Va

16 (a) Informant Ben Calaboun

(b) Address 1406 Penna an

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Anasub. Mem Park

Location Balto. City

18 (a) Funeral director Archibald J. Laddis

(b) Address 2101 M. C. Callahan St

19 SEP 18 1943

(Date filed by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1943 at 1:15 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from Aug 28 1943 to Sept 15 1943

and that I last saw him alive on Sept 15 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

2 weeks

Due to

Hypertensive Crisis
Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Ralph W. Reckling

Address 426 N. E. Ave

Date signed 7/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write clearly and legibly.

G 08252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08252
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 246 N. Pearl St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 46 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 246 Pearl St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

William Braum

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

Married6 (b) Name of husband or wife Jessie Braum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19th 1870

8. AGE: Years

72

Months

9

Days

26

If less than one day

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Cabinet MakerFATHER
MOTHER

12. Name

William Braum

13. Birthplace

Germany

14. Maiden Name

Maria Froeder

15. Birthplace

Germany

16 (a) Informant

Joseph E. Braum

16 (b) Address

4220 Howard Ave17 (a) Burial

(Burial, cremation, or other)

(b) Date thereof 9/18/43

(month) (day) (year)

17 (c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd Balto. Md.

18 (a) Funeral director

W. Cook Inc

(b) Address

127 St. Paul St.

18 (c) Address

1663 W. 7th St.

18 (d) Address

1663 W. 7th St.

18 (e) Address

1663 W. 7th St.

18 (f) Address

1663 W. 7th St.

18 (g) Address

1663 W. 7th St.

18 (h) Address

1663 W. 7th St.

18 (i) Address

1663 W. 7th St.

18 (j) Address

1663 W. 7th St.

18 (k) Address

1663 W. 7th St.

18 (l) Address

1663 W. 7th St.

18 (m) Address

1663 W. 7th St.

18 (n) Address

1663 W. 7th St.

18 (o) Address

1663 W. 7th St.

18 (p) Address

1663 W. 7th St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15th 1943 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug. 15 1943 to Sept 15 1943.and that I last saw him alive on Sept 14 1943

Immediate cause of death

Duration

Due to Carcinoma of prostate with metastasesDue to metastases

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James BrownAddress 1663 W. 7th St.Date signed 9/18/43

correct age is especially important. Physicians: please print name and address.

08253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08253

T.N. 82184

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5014 Frederick Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Adah Schley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1864

8. AGE: Years Months Days If less than one day

78

10

18

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name John Schley

13. Birthplace Maryland

14. Maiden Name Sophia Holler

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 9/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or burying place Mt. Olivet

Location

Baltimore Md.

18 (a) Funeral director William Cook & Co

(b) Address 1217 St. Paul St

SEP 18 1943

(Date of registration) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1943 at 12:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/17 1943 and that I last saw her alive on 9/17 1943

Immediate cause of death

Bronchopneumonia

Duration

2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. L. Sargman

Address

BCH

Date signed

9/17

08254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08254
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3119 Marisco Ave

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 3119 Marisco Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Albert Gallatin

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed or
divorced. Married

6 (b) Name of husband or wife

Clara E. Gallatin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1873

8. AGE:

Years

Months

Days

If less than one day

70317

hr.

min.

9. Birthplace

Pa.

10. Usual Occupation

Retired Linotype Operator

11. Industry or business

Balto. Steel

12. Name

Samuel Gallatin

13. Birthplace

14. Maiden Name

Mary Perling

15. Birthplace

16 (a) Informant

Geo. S. Gallatin

(b) Address

1436 Winston Rd

17 (a)

Burial

(b) Date thereof

9/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Moreland Park

Location

Parkville Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

19

SEP 18 1943Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17th 1943 at 4:30 M21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1943 to Sept. 17 1943and that I last saw him alive on Sept. 17 1943

Immediate cause of death

Carcinoma of stomach

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations:

of autopsy:

None

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Siobhán J. Luy

Address

2322Eastman Place

Date signed

9/17/43

G 08255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08255

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5/14/43

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~MD~~ Va. (b) County

(c) City or town Norfolk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1139 Westmoreland Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME WALTER MORGENSEN

3 (b) If veteran, name war
World's War3 (c) Social Security Account
No.4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Odie May Morgenson
Single na: Andrews

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1884

8. AGE: Years 59 Months 7 Days 28 27 If less than one day
hr. min.

9. Birthplace Eureka, California

(Town, county, and state)

10. Usual Occupation Lieut. C. G.

11. Industry or business "

12. Name Sophus Morgenson

13. Birthplace Copenhagen, Denmark

14. Maiden Name Carolina Johnson

15. Birthplace Copenhagen, Denmark

16 (a) Informant Records, U. S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9/18/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory U. S. National

Location Arlington Va.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

SEP 18 1943

VB 184

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 16, 1943, 12:50 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 2, 1943, to Sept. 16, 1943,
and that I last saw him alive on Sept. 16, 1943

Immediate cause of death

Peritonitis

Duration
3 wks.Due to Perforation of colon and
abscess

Unk.

Due to Adenocarcinoma of sigmoid,
advanced, with generalized abdominal
metastases post-operative
& radiation residual.

Unk.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: -

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 9/16/43

Va-13505

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. **C 08256**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *do.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *2252 Madison Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Arthur Roland Davis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

*C*6 (a) Single, married, widowed, or
divorced. *M.*6 (b) Name of husband or wife *Maud Davis*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 15 - 1908*8. AGE: Years Months Days If less than one day
34 36 11 1 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

John T Davis

13. Birthplace

Ind

14. Maiden Name

Florence E. Smith

15. Birthplace

Ind

16 (a) Informant

Chester A Smith

(b) Address

2252 Madison Ave

17 (a)

Burial (b) Date thereof *Sept 20 - 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

St Auburn

Location

18 (a) Funeral director

Shirley H. Chase Hye

(b) Address

638 N. Gilman St

SEP 18 1943

Walter Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 16* 19*43*, at *8* *P* M21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in myopinion resulted from: ☒ natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Ruptured
aneurysm of aorta*

Due to

Syphilitic aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature

Robert Lee Grattan M.D.
Medical Examiner.

Date signed

Sept. 17 1943

08257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08257

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 Shelton Street

(c) Hospital or institution:

Addiction Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 42.

(e) Length of stay in Baltimore (yrs., mos., or days) 40 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3116 Roseburg Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.

3 (a) FULL NAME

Otto A. Pfaff

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Emma Pfaff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 - 1866

8. AGE: Years 77 Months 56 Days 11 If less than one day hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Max Haidel

(b) Address 7609 N 3rd St N.W. Va

17 (a) Burial, cremation, or removal (b) Date thereof 7/18/43 (month) (day) (year)

(c) Cemetery or crematorium Holy Cross Cem G. A. Co. Md. Location

18 (a) Funeral director Leonard J. Rush

(b) Address 5305 Harford Rd

19 (a) SEP 18 1943 (b) Huntington Williams, M.D.

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Sept 15 1943, and that I last saw him alive on Sept 15 1943.

Immediate cause of death

Carcinoma Stomach

Duration

8 mos

Due to

Due to

Other Conditions Gas Perforated Duodenum

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Gas SO Stomach

23. Signature 5878 Harford Rd M.D.

Address 5878 Harford Rd Date signed 9/17/43

G 08258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08258

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *607 Sharp St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Anthony Henley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec. 16, 1903*

8. AGE: Years Months Days If less than one day

*39**9**-*

hr.

min.

9. Birthplace

Augusta, Ga.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Henry Henley

13. Birthplace

Ga.

MOTHER

14. Maiden Name

Elmira Wright

15. Birthplace

S. C.

16 (a) Informant

Louis Henley

(b) Address

607 Sharp St.

17 (a)

Burial

(b) Date thereof

9-19-47

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

mt. columbia

Location

a a c m d

18 (a) Funeral director

Joseph L. Brown

(b) Address

108 W. Montgomery St.

19 SEP 18 1943

(Date rec'd by registrar)

William M. B.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-16-* 19*43*, at *5:30* A M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Acute Myocardial Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Howard J. Anderson* M.D.Date signed *9-16-43*

Medical Examiner.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08259

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Charlottesville Hospital 17-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *547 West Hoffman St*
(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME

Barbara Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3/26/43*

8. AGE: Years Months Days If less than one day

5 19 hr. min.

9. Birthplace *Balto. Md.*
(Town, county, and state)

10. Usual Occupation *none*

11. Industry or business

12. Name *Collarmack Powell*

13. Birthplace *Halifax Va.*

14. Maiden Name *Mary Hughes*

15. Birthplace *Lynchburg Va.*

16 (a) Informant *Mary Hughes*

(b) Address *547 W. Hoffman St*

17 (a) *Burial* (b) Date thereof *Sept. 18, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Calvary*

Location *Anne Arundel Co. Md.*

18 (a) Funeral director *Adolphus Halstead*

(b) Address *918 Druid Hill Ave.*

SEP 18 1943

(b) *Huntington Williams, M.D.*
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 15 1943* at *10:15* P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 15 1943* to *Sept 15 1943*, and that I last saw her alive on *Sept 15 1943*.

Immediate cause of death

Non-Specific Diarrhea *1 week*

Due to *Acute Gastroenteritis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations.

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury *Y. Bawfield*

23. Signature *Y. Bawfield*

Address *Provident Hospital* Date signed *9-18-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08260

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 300 Beechfield Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 300 Beechfield Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

William J. Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Helen R. Holbein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **** 1983

8. AGE: Years Months Days If less than one day

60 Yrs.

hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Wholesale Fruit

12. Name William J. Quinn

13. Birthplace Maryland

14. Maiden Name Mary Hogan

15. Birthplace Maryland

16 (a) Informant Helen R. Quinn

(b) Address 300 Beechfield Ave.

17 (a) Burial (b) Date thereof 9/12/24

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director H. W. Meadison

(b) Address 805 N. Calvert

19 SEP 18 1943 (b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1943. 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1921 to 9/11 1943.

and that I last saw him alive on 9/11 1943.

Immediate cause of death

CORONARY THROMBOSIS

Duration

4 hrs

Due to HYPERTENSION and ARTERIOSCLEROTIC C.V. DISASE

12 YRS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. Raymond Pitts

Address 1127 N. Calvert St Date signed 9/12/43

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08261

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(b) City or town Baltimore Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3138 Kenwick Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MARY Elizabeth Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Herbert J. Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19-1879

8. AGE: Years Months Days If less than one day

64

8

23

hr.

min.

9. Birthplace Stewartstown Pa.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Henry J. Hubley

13. Birthplace Penna

14. Maiden Name Eliza Waltham

15. Birthplace Penna

16 (a) Informant Mrs Gertrude Volz

(b) Address 232 Sherman Ave

17 (a) Burial (b) Date thereof Sept 20-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Oh

Location Baltimore Md

18 (a) Funeral director Frank H. Serty

(b) Address 814 N. 36 St

19 (a) SEP 18 1943

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1943 at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1943 to Sept. 17 1943 and that I last saw her alive on Sept. 16 1943.

Immediate cause of death

Uremia

Due to Carcinoma of cervix uteri

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Peritonitis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. E. McMillan

Address University Hospital Date signed 9/17/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08262
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1323 Brunt St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1323 Brunt St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mae A. Garrison

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 215-01-8518

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or

divorced Married

6 (b) Name of husband or wife Holland W.

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 5/9/1903

8. AGE: Years Months Days If less than one day

40

4

5

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Domestic Presser

11. Industry or business White Laundry

12. Name Allen Aquilla

13. Birthplace Baltimore, Md.

14. Maiden Name Ellen

15. Birthplace Baltimore, Md.

16 (a) Informant Holland W. Garrison(H)

(b) Address 1323 Brunt St.

17 (a) Burial (b) Date thereof 9/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l Pk.

Location Balto. Co. Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 514 N. Calhoun St.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14/43 19 at 7:25 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from May 15 1943 to Sept 14 1943
and that I last saw h. live on Sept 14 1943.

Immediate cause of death

Carcinoma uterus

Due to

Duration

14 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Watters M.D.

Address 5154 Arlington Date signed 9/17/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

08263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08263

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Senatoga & Calvert*

(c) Hospital or institution:

Mary Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *1/2 hr.*(e) Length of stay in Baltimore (yrs., mos., or days) *1/2 hr.*

3 (a) FULL NAME

Baby Lila Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

*W*6 (a) Single, married, widowed, or divorced *5*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 11, 1943*8. AGE: Years Months Days *1/2 hr.* min.9. Birthplace *Mary Hospital*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *George Walker*13. Birthplace *England*14. Maiden Name *Mildred Hatter*15. Birthplace *Baltimore*16 (a) Informant *Mrs. Walker*(b) Address *9516 Hartford Road*17 (a) *Burial* (b) Date thereof *9-18-43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Backwood*

Location

18 (a) Funeral director *L. J. Ruck*(b) Address *5-3005-1 Hartford Rd*19 *SEP 18 1943* (b) *Huntington Williams, M.D.*

VS 156

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County *Balto.*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *9516 Hartford Road*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 17* 19*43* at *2 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 17 1943* to *Sept 17 1943* and that I last saw him alive on *Sept 17 1943*

Immediate cause of death

Premature Birth

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *L. R. Sigler*Address *Mary Hospital* Date signed *9/17/43*

M. D.

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G 08264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08264

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4707 Frederick Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4707 Frederick Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

WILLIAM H. IGLEHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife Hattie Iglehart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1870

8. AGE: Years Months Days If less than one day

73

7

12

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Machinist's Helper

11. Industry or business

12. Name Paul Iglehart

13. Birthplace Balto., Md.

14. Maiden Name Carrie Reese

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Hilda E. Nelson

(b) Address 4707 Frederick Ave.

17 (a) burial (b) Date thereof Sept. 20, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto., Md.

18 (a) Funeral director Lasswell Funeral Home

(b) Address 7401 Belair Road

SEP 18 1943

VB 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16th, 1943, 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943, to Sept 16 1943 and that I last saw him alive on Sept 16 1943.

Immediate cause of death

Cerebral Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 4209 H and M Date signed 9-17-43

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

440988
08265BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08265

Registered No.

55B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Fullerton

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3613 Putty Hall

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Calvin Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 4th 1922

8. AGE:

Years

Months

Days

If less than one day

26

2

13

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER

12. Name

William Johnson

13. Birthplace

Md.

14. Maiden Name

Emma Brynner

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 21 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

Brooklyn, Md.

18 (a) Funeral director

Fasham Funeral Home

(b) Address

74 of Belair Rd.

19 (a)

SEP 18 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 17

1943

20

21. I certify that death occurred on the date above stated; that I attended deceased from

Sept 9 1943 to Sept 17 1943

and that I last saw him alive on Sept 17 1943

Immediate cause of death

Respiratory failure

Due to Ewing's tumor of lung

Due to Ewing's tumor of left hip

Other Conditions

Brain metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert Day

Address

Johns Hopkins

Date signed

9/17/43

08266

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08266

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2803 Garrison Blvd

(c) Hospital or institution:

Garrison Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Anneslie
(If outside city or town limits, write RURAL and give town)(d) Street No. 7113 Sheffield Rd.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPHINE VICTORIA ROBERTS

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife Marion A. Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1870

8. AGE: Years Months Days If less than one day
73 2 1 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
MOTHER

12. Name Benjamin Rawlings

13. Birthplace Baltimore, Md.

14. Maiden Name

15. Birthplace

16 (a) Informant Mr. Norman E. Wilson

(b) Address 7113 Sheffield Rd.

17 (a) Burial (b) Date thereof 9/18/1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

SEP 18 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1943, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12, 1943, to Sept. 16, 1943, and that I last saw him alive on Sept. 15, 1943.

Immediate cause of death

Carcinoma of sigmoid

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 1942

Major findings of operation:

Carcinoma

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Homer L. Todd

Address 735 N. Fulton Date signed 9/17/43

Duration

1 1/2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08267
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 5601 Park Heights Ave.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 E. 44 th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Maude A. Duke

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced
Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1905

8. AGE: Years 38 Months 2 Days 25 26 hr. min.

9. Birthplace Brooklyn, N. Y.

(Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business

12. Name Walter Kramer

13. Birthplace New York

14. Maiden Name Anna O'Leary

15. Birthplace New York

16 (a) Informant Miss Ada Kramer (Sister)

(b) Address I301, 15 th Street Wash. D.C.

17 (a) Removal (b) Date thereof 9/18/43
(Burial, cremation, or removal) (month) (year)(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Maurice J. Flynn

(b) Address I426 Light Street

SEP 18 1943

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1943 at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1943 to 9/19 1943, and that I last saw him alive on 19

Immediate cause of death Death Cardiac Dilatation

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 528 Date signed 9/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08268
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

19 N. Streeter

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas Gillard

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

*Verona*6 (c) If alive, give age *58* years

7. Birth date of deceased (mo., day, yr.)

11-4-85

8. AGE:

Years

Months

Days

If less than one day

*57**10**13*

hr.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual Occupation

Oilier

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Gillard

13. Birthplace

England

14. Maiden Name

Minnie?

15. Birthplace

Germany

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cape Lane

Location

Eastern Ave

18 (a) Funeral director

*John B. Moran**SEP 18 1943*

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 17 1943 1 P. M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 16 1943* to *Sept. 17 1943*and that I last saw him alive on *Sept. 17 1943*Immediate cause of death *Acute pulmonary edema*

Duration

Due to

Left heart failure

Due to

*acute stenosis +**insufficiency (? calcified)*

Other Conditions

*Peripheral**vascular disease*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

T.B. Schwartz

Address

J. H. Hosp.

Date signed

9/17/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T.N

83670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 319 E. 21st. St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Frank Noakes

3 (b) if veteran, name war

3 (c) Social Security Account

No. 18-09-9128

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife. *Theresa Noakes*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1886

8. AGE: Years Months Days If less than one day

57

2

21

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Service Station Operator

11. Industry or business

FATHER
MOTHER

12. Name Thomas Noakes

13. Birthplace Maryland

14. Maiden Name Mary Ida Rhodes

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address

4940 Eastern Ave Records

17 (a) Burial (b) Date thereof Sept 20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location Funderburk Rd. Ext.

18 (a) Funeral director J. Lee Odey

(b) Address 4646 York Rd.

SEP 19 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1943 at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1943 to 9/17 1943.

and that I last saw him alive on 9/17 1943.

Immediate cause of death

*Lucie C. V. Noakes -
arterio insuff. + cardiac
failure*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

*as above; acute arthritis
of autopsy.*

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Sengman

Address B.S.H. Date signed 9/17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 08270

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1125 E. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

24 Days

3 (a) FULL NAME

John Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 11, 1943

8. AGE: Years Months Days

3

5

If less than one day

hr.

min.

9. Birthplace

Charlotte, N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John Lee

13. Birthplace

N.C.

14. Maiden Name

Elizabeth Young

15. Birthplace

N.C.

16 (a) Informant

Mozell Young

(b) Address

1125 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof

19/18/43

(c) Cemetery or crematory

mt Calvary

Location

18 (a) Funeral director

Thoy O. Wilson

(b) Address

1000 Parkview Ave

19 (a)

SEP 19 1943

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1125 E. Lexington St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 16 1943 at 9:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 14 1943 to Sept 16 1943, and that I last saw him alive on Sept 16 1943.

Immediate cause of death

Acute Bronchitis
Due to
Pneumonia

Duration

Sept 13 1943

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at/work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

1210 ...
Date Sept 18 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08271

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2823 Huntington Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Marjorie Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-10-19

8. AGE:

Years

Months

Days

If less than one day

34

-

8

hr.

min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Henry Talbot

13. Birthplace

?

MOTHER

14. Maiden Name

Maudie Coleider

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Buchanan

Location

West Vg.

18 (a) Funeral director

John O. McNeil

(b) Address

1900 Eutaw Pl

19 (a)

SEP 19 1943

(b)

Registrar

98 150

Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1943 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Rheumatic
ht disease

Due to acute decompensation

Due to mitral stenosis

Other Conditions Type XIV
pneumonia

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John H. Cunningham

Address 5 N N Date signed 9-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08273
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1647 Ruxton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1647 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Morton H. Schless

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-07-2043

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1914

8. AGE: Years 29 Months 1 Days 7
If less than one day hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business Office Clerk

12. Name Benjamin Schless

13. Birthplace Russia

14. Maiden Name Rose Rosenberg

15. Birthplace 1647 Russia Ave

16 (a) Informant Benjamin Schless

(b) Address 1647 Ruxton Ave

17 (a) Burial (b) Date thereof Sept, 19, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 26 W North Ave

SEP 19 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

4:30

20. DATE OF DEATH September 18, 1943 at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-16-1943 to Sept-18-1943, and that I last saw him alive on Sept-18-1943.

Immediate cause of death

subacute endo-carditis

Due to

Rheumatic valvular

Due to

heart-disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Herman Heindel M. D.

Address 2414 Entaw Pl Date signed 9/18/43

Duration

about
four
months

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08274

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Sinai Hospital**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **35 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County
(c) City or town **Balto**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1056 W Baltimore St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Harry Fisher**

3 (b) If veteran, name war 3 (c) Social Security Account
216 01 5793

4 Sex **Male** 5 Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Lillian**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1889**

8. AGE: Years **54** Months Days If less than one day
hr. min.

9. Birthplace **Russia**
(Town, county, and state)

10. Usual Occupation **Tailor**

11. Industry or business
12. Name **Zelik Fisher**
13. Birthplace **Russia**

14. Maiden Name **Unknown**
15. Birthplace **Russia**

16 (a) Informant **Morris Fisher**
(b) Address **3500 Trainor Ave**

17 (a) **Burial** (b) Date thereof **Sept 19/43**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory **Hesper Friendship**
Location **E Baltimore St**

18 (a) Funeral director **Ed L. Williams, Inc**
(b) Address **1124-26 W. North Ave**

19 (a) **Huntington Williams, M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 17, 1943 at 4:40 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 6, 1943 to Sept. 17, 1943** and that I last saw him alive on **Sept. 17, 1943**.

Immediate cause of death **Pneumonia**

Due to **Cerebral Vascular accident**

Due to **Hypertension**

Other Conditions **Hypertensive C.V.D. Renal insufficiency**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Henry M. M. D.**
Address **Sinai Hosp.** Date signed **9-17-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08275

JL - 83801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 702 Vine St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

George Cook

3 (b) If veteran, name war

3 (c) Social Security Account

No. Yes

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ella Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1880

8. AGE: Years Months Days

62

8

20

If less than one day

hr.

min.

9. Birthplace Balto

(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
MOTHER

12. Name ?

13. Birthplace ?

14. Maiden Name Emma

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial

(b) Date thereof 9-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director

(b) Address 578 W. Biddle St.

19 (a) Date of death

Sept. 19, 1943

VS 368

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1943, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1943, to 9-15 1943,

and that I last saw him alive on 9-15 1943.

Immediate cause of death

Generalized Peritonitis

Due to Gastric Cancer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-14-43

Major findings of operations: none

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald B. Smith

Address Baltimore City Hosp Date signed 9-15-43

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08276

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore, Maryland

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

VICTORIA A. SIMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 29 - 1943

8. AGE:

Years

Months

Days

If less than one day

318

hr.

min.

9. Birthplace

Balta, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Franklin Simpson

13. Birthplace

Md.

MOTHER

14. Maiden Name

Bessie Simpson

15. Birthplace

Md.

16 (a) Informant

(b) Address

1312 N. Arlington Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

St. Gabriel Cem.

Location

Balta, Md.

18 (a) Funeral director

(b) Address

578 W. Bond St.Huntington, Williams, Md.

(b) Registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

811 N. Arlington Avenue

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

3:05 P.

20. DATE OF DEATH September 17, 1943 at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Diarrhea, infantile.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

H. Z. Wallensten

M.D.

Date signed

9-18-43

Medical Examiner.

SEP 19 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

440 63277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08277

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1800 Letitia Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Leila Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife HARRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-85

8. AGE: Years 58 Months 5 Days 22 hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own time

12. Name George Wolfe

13. Birthplace Md

14. Maiden Name Catharine Jordan

15. Birthplace Ireland

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 20-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory David Ridge

Location Pikesville

18 (a) Funeral director Elizabeth Wolfe Inc

(b) Address 115 E West St.

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1943 at 1155 P

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1943 to Sept 16 1943, and that I last saw her alive on Sept 16 1943.

Immediate cause of death

Obstruction of portal Vein

Due to operation for Carcinoma common duct

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/16/43

Major findings of operation: Carcinoma of common duct.

of autopsy:

Duration

-10 hrs.

3 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Longmire Jr

Address Johns Hopkins Hosp Date signed 9/17/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08278

440483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08278

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1035 Homewood Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna Timmings

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

John Timmings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-15-66

8. AGE:

Years

Months

Days

If less than one day

77 yrs

3 mo

2

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

James Reddy

13. Birthplace

Ireland

MOTHER

14. Maiden Name

Bridget Hart

15. Birthplace

Ireland.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept. 21, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cemetery

Location

8300 W. E. Fisher St.

18 (a) Funeral director

John W. Conklin

(b) Address

924 E. Eagle St.

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1943 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1943 to Sept. 17, 1943 and that I last saw her alive on Sept. 17, 1943.

Immediate cause of death Bacterial endocarditis

Due to Ohem strap

Due to

Other Conditions arteriosclerotic C-V disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Bact. endocarditis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(d) Means of injury

23. Signature

John R. Birmingham

Address

J H H

Date signed

9-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08279

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08279

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland *E. Monument*

(b) Street address *Senai Hosp*

(c) Hospital or institution:

Senai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *0.02.*

(e) Length of stay in Baltimore (yrs., mos., or days) *5 wks.*

3 (a) FULL NAME

Margaret Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife *Samuel Jones*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2 8 1895

8. AGE:

Years

Months

Days

If less than one day

48

2

2

hr.

min.

9. Birthplace *Fulton Co. Pa.*

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

FATHER
MOTHER

12. Name *Leona Bishop*

13. Birthplace *Pa*

14. Maiden Name *Martha Barry*

15. Birthplace *Pa*

16 (a) Informant *M.*

(b) Address *1006 E 25th St*

17 (a) *Burial*

(b) Date thereof *Sept 22 48*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Buck Valley Chh. Co.

Location

Buck Valley Pa

18 (a) Funeral director

Rev. E. Meyer Jr

(b) Address

1512 Hollins St

19 (a)

(b)

SEP 19 1948

H. E. Meyer Jr

2. USUAL RESIDENCE OF DECEASED:

(a) State *Pa* (b) County *Fulton Co.*

(c) City or town *Home is in country*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *700 St. Mark*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/18* 19*43* at *8 30* *P*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/18* 19*43* to *9/18* 19*43* and that I last saw him alive on *O.A.* 19*43*

Immediate cause of death

Cerebral - malar accident

Due to

Hypertension

Due to

Myocardium

Other Conditions

Hyp. Ht. dis.

Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: *C-V accident, T.O., Myocardium*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Leonard E. Meyer

Address

Senai Hosp.

Date signed

9/19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08280

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19. Date of registration

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18

1943

at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 to Sept 18, 1943, and that I last saw him alive on Sept 17, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date

9/18/43

G 08281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08281

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3520 Hester Rd

(c) Hospital or institution:

Shrivers Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

80

(e) Length of stay in Baltimore (yrs., mos., or days)

80

2. USUAL RESIDENCE OF DECEASED:

(a) State

Maryland

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1001 Ridgely St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

Charles Harig

3 (b) If veteran, name was

No

3 (c) Social Security Account

No

None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Elizabeth Harig

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

June 11, 1856

8. AGE:

Years

Months

Days

If less than one day

87

3

6

hr.

min.

9. Birthplace

Racineville Kentucky

(Town, county, state)

10. Usual Occupation

Glass Blower

11. Industry or business

Womdell Bros

FATHER

12. Name

John Harig

13. Birthplace

unknown

MOTHER

14. Maiden Name

Gertrude Hunt

15. Birthplace

unknown

16 (a) Informant

Gertrude Hammer

(b) Address

1001 Ridgely St.

17 (a) Burial

(b) Date thereof

Sept 20, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

City

18 (a) Funeral director

Mrs. John N. Tempelton

(b) Address

801 W. Fayette St

19 (a)

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 17 1943 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1943 to Sept 17 1943

and that I last saw him alive on Sept 17 1943

Immediate cause of death

Carcinoma of stomach

Duration

7 mos

Due to

Due to

Other Conditions

Hypertension, Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J S A Stearns

Address

2878 Hartford Rd

Date signed

9/18/43

SEP 19 1943

8282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08282

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1829 N. Chappel St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1829 N. Chappel St

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 19 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-16

1943, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1943, to Sept. 16, 1943, and that I last saw her alive on Sept. 16, 1943.

Immediate cause of death

Broncho-pneumonia

Duration

2 days

Due to

Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

A. Weiss

M. D.

Address 1927 E. North Ave. Date signed 9/18/43

08283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08283
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1327 N. Milton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No 1327 N. Milton Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

Female White

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27th 18658. AGE: Years 78 Months 5 Days 20 If less than one day
hr. min.9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Adam Rahla

13. Birthplace Va

14. Maiden Name Julia Vancourt

15. Birthplace Va

16 (a) Informant Mrs. Wardell

(b) Address 1327 N. Milton Ave

17 (a) Burial (b) Date thereof Sept 20th 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Trinity
Location O'Donnell St Ext

18 (a) Funeral director Leo B. Cook

(b) Address 1701-03 N. Patt Park Ave

P 19.1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17th 1943 at 5:15 PM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 3/11 1943 to 9/17 1943.
and that I last saw him alive on 9/16 1943.

Immediate cause of death

Broncho pneumonia

Due to Chs. Arthritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Max Bauman

Address 1501 N. Milton Ave Date signed 9/18/43

Duration
3 weeks

15 years

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 08284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08284

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 3023 1 Baltimore St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3023 1 Baltimore St

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Bartolo

Andreis

3 (b) If veteran, name war

World War Veteran

3 (c) Social Security Account

No. 215-09-6742

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1888

8. AGE: Years Months Days If less than one day
54 11 27 20 hr. min.9. Birthplace Malcesine Italy
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Crown Cork Seal

12. Name Bartolo Andreis

13. Birthplace Italy

14. Maiden Name Domenica Saglia

15. Birthplace Italy

16 (a) Informant Elda Faraone

(b) Address 3700 Overview Rd.

17 (a) Burial (b) Date thereof Sept. 18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Natio. Ceme.
Location 5501 Fredorik Rd.

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Morley St.

19 SEP 19 1943 (b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1943, at 2:45 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Chronic myocardial
degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed Sept 17 1943

G 08285

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08285

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) 6 or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 321 S. Ellamont St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Dominic Mascetti

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 717-07-6470

4. Sex

male

5. Color or race

Wh. Fr.

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) FEB. 8-18928. AGE: Years Months Days If less than one day
51 7 9 hr. min.

9. Birthplace

Italy
(Town, county, and state)10. Usual Occupation WATCH MAN11. Industry or business CORNER GOLDMAN-TAILOR-SHOP12. Name GIUSEPPE MASCETTI13. Birthplace ITALY14. Maiden Name CANDIDA ODIO15. Birthplace ITALY16 (a) Informant IRENE MASCETTI (WIFE)(b) Address 321 S. ELLAMONT ST.17 (a) BURIAL (b) Date thereof SEP-21-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory NEW CATHEDRALLocation OLD FREDERICK RD.18 (a) Funeral director Frank Della Noce(b) Address 52 N. Monley St

SEP 10 1943

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1943, at 12:45 M21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury September 15, 1943 4:10 P.M.(b) Where did injury occur? Frederick Rd. 2nd block(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no(d) Means of injury Automobile struck by truck23. Signature Robert Lee Frasier, M.D.

Medical Examiner

Date signed Sept. 17, 1943

G 08286

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08286
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(d) Street No. 2435 - Smith Ave. Morris Pk

(If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Traveline Glen Pinnix

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-12-1358

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Alice Pinnix

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

Jan. 10, 1911

8. AGE:

Years

Months

Days

If less than one day

32

7

11

hr.

min.

9. Birthplace

N. Carolina

(Town, county, and state)

10. Usual Occupation

Ship-fitter

11. Industry or business

Self. Ship-B. Corp.

FATHER

12. Name

Banner Pinnix

13. Birthplace

N. Carolina

MOTHER

14. Maiden Name

Alice Sparks

15. Birthplace

N. Carolina

16 (a) Informant

Fred Pinnix

(b) Address

906 West Court, Brooklyn-Md.

17 (a)

Ship

(b) Date thereof

9-19-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Folk

Location North Carolina

18 (a) Funeral director

Bernard C. Harlow

(b) Address

121 E. West St

1943

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-1943 at 6 PM

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-17- at 7 P. M.

(b) Where did injury occur? 2416 Annapolis Rd

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work? No

(d) Means of injury Felled with fire, head struck

23. Signature Howard J. Glusko

M.D.

Date signed 9-19-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08287

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 19 1943

19. Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 08288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08288

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: *St. Agnes*(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) *37nd.* (b) County(c) City or town: *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2413 N. Calvert St. Apt. A*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Florence E. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account

No.

NONE

4. Sex

Female

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife: *William N.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *12/24/1908*8. AGE: Years Months Days If less than one day
74 73 8 23 hr. min.

9. Birthplace

Md. (Baltimore)

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

*At Home*12. Name *Littleton Long*

13. Birthplace

*Md.*14. Maiden Name *Catherine Tucker*

15. Birthplace

*Md.*16 (a) Informant *Dr. Francis*

(b) Address

*St. Agnes Hosp.*17 (a) *Burial* (b) Date thereof *9/20/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

*A.A. Co. Md.*18 (a) Funeral director *William Cook Inc.*

(b) Address

127 S. Paul St.

SEP 19 1943

Huntington Williams

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 17th* 19*43*, at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive on *9/12/1943*Immediate cause of death *Carcinoma of Sigmoid c metastasis*

Duration

Due to

Due to

Other Conditions *Terminal Pneumonia*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: *Carcinoma of Sigmoid c metastasis*
of autopsy: *Carcinoma Sigmoid c metastasis*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Wm. T. Mue

Address

*St. Agnes Hosp.*Date signed *9/18/43*

G 08289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08289

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

850 Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

3 (b) If veteran, name war

World #1

(c) Social Security Account

No. NONE

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Margaret T. Shallenberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

June 2nd 1895

8. AGE:

Years

Months

Days

If less than one day

48

3

1415

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Proprietor

11. Industry or business

Locksmith Business

FATHER

12. Name

Harry T. Shallenberger

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Katherine Hasfuer

15. Birthplace

Balto. Md.

16 (a) Informant

Margaret T. Shallenberger

(b) Address

850 Park Ave

17 (a)

Burial

(b) Date thereof

Sept 2nd 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Co. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 S. Paul st

19 (a)

Date of death

(b) Place of death

Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

850 Park Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

Shallenberger

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 17

1943, at 7³⁰ AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary

occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert L. Graham, M.D.

Medical Examiner

Date signed

Sept 17 1943

G 08290

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08290

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

U. S. Marine Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

England

(b) County

(c) City or town

Liverpool

(d) Street No.

93 St Martin, Cottages

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

Yes Britain

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

M

5. Color or race

W

3 (c) Social Security Account

No.

NONE

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Catherine Coffey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

45

hr.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual Occupation

Mariner

11. Industry or business

12. Name

Walter Coffey

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Records

(b) Address

U. S. Marine Hospital

17 (a)

Burial

(b) Date thereof

9/21/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Co. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

127 St. Paul St

(c) Date rec'd by Registrar

September 19, 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16

1943, at 9²⁰ PM

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Rupture of

liver; compound fracture of

right lower leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Sept. 10 1943

24/1 M.

(b) Where did injury occur?

Fort Ave near Town St

(c) Did injury occur at home, on farm, industrial place, in public

place? street

While at work? No

(d) Means of injury

pedestrian struck by auto

23. Signature

Robert Lee Graham M.D.

Date signed

Sept 17 1943

Medical Examiner

G 08291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08291
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 910 S Conkling St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 910 S Conkling St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MinnieMullaney

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife William Mullaney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27-18948. AGE: Years Months Days If less than one day
49 0 26 19 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual Occupation House wife11. Industry or business at Home12. Name Abner Altvater13. Birthplace Baltimore Md.14. Maiden Name Margaret Bryan15. Birthplace Baltimore Md.16 (a) Informant James Mullaney (Son)(b) Address 2412 Ashland Ave17 (a) Burial (b) Date thereof Sept. 20-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. StanislausLocation Odornell St.18 (a) Funeral director Lilly and Geiger INC.(b) Address 403 S. Wolfe St.P9 1-9 1943 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1943, at 8 AM21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Bronchitis
asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.Date signed Sept. 17 1943

08292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08292

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1610 Druid Hill ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

3 (a) FULL NAME

Alma Bouldin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Charles Bouldin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1909

8. AGE:

Years

Months

Days

If less than one day

34

hr.

min.

9. Birthplace

na

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name Adolphus Harris

13. Birthplace

na

14. Maiden Name Laura Steward

15. Birthplace

na

16 (a) Informant Mamie Bradley

(b) Address 1610 Druid Hill ave

17 (a)

Burial

(b) Date thereof 9-21-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Palmyra na

Location

na

18 (a) Funeral director

George S. Nelson

(b) Address

1803 Prestman St

19 (a)

Huntington Williams, M.D.

Registrar

SEP 20 1943

VB 184

2. USUAL RESIDENCE OF DECEASED:

(a) State md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1610 Druid Hill ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1943 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 to 9/18 1943 and that I last saw him alive on 9/17 1943

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

4 hrs

16 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

08293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08293
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18th 1943 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Sept 18 1943, and that I last saw him alive on Sept 18 1943.

Immediate cause of death

Coronary Thrombosis
arteriosclerosis and gangrene
Due to renal changes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. D.

Address

Date signed

G 08294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G 08294

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1517 Lenox St.

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1/4

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or repository

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 17

1943, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1943 to Sept 17 1943, and that I last saw him alive on Sept 17 1943.

Immediate cause of death

Arteriosclerosis

Due to

Due to

Other Conditions

Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed 9-18-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 20 1943

Huntington Williams

G 08295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08295

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia (b) County(c) City or town Richmond(d) Street No. 1221 W. Carey St

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 10, 1906

8. AGE:

Years

Months

Days

If less than one day

37

3

3

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Weeder

11. Industry or business

Fairfield Shipyards

FATHER

12. Name

James P. Parks

13. Birthplace

Va.

MOTHER

14. Maiden Name

Julia Parks

15. Birthplace

Va.

16 (a) Informant

Rosa M. Parks

(b) Address

1114 Penna. Ave.

17 (a)

Burial

(b) Date thereof

9/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md

18 (a) Funeral

William A. Jackson

(b) Address

916 Penna. Ave

19 (a)

(Date rec'd by registrar)

Sept. 20, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1943, at 7 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

skull

Fracture of

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 13 1943 12 AM

(b) Where did injury occur Argyle Ave near Lanvale

(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? no

(d) Means of injury Blunt force

23. Signature Robert L. Glatton, M.D.

Date signed Sept. 14 1943

VS SEP 20 1943

08296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08296

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 21 N Pearl St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Anna Marek

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 13-1879

8. AGE: Years

63

Months

9

Days

5

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name

William L Marek

13. Birthplace

Ohio

14. Maiden Name

Augusta Starickoff

15. Birthplace

Baltimore

16 (a) Informant

George A Marek

(b) Address

804 E 35 St17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept 21-43

(c) Cemetery or crematory

Westwood Cem

Location

18 (a) Funeral director

Charles P Toyell

(b) Address

2427 Edmondson Ave

19 (a)

SEP 20 1943

(b)

H. H. Miller, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

21 N Pearl St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 151943, at 7 PM21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943, to Sept 15 1943.and that I last saw him alive on Sept 12 1943.

Immediate cause of death

Chor. Myocarditis

Duration

3 yrs

Due to

Due to

Other Conditions

Parkinson's disease5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Chas. J. Keller

Address

222 W. Monument

Date signed

M. D.

Sept 20

G 08297

MJ-48658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08297

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. 3 yrs, 11 mos, 23 days

(e) Length of stay in Baltimore (yrs, mos., or days) Life

3 (a) FULL NAME

Anna Dougherity

3 (b) If veteran, name war

3 (c) Social Security Account No. N/A

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife

Jim Slater

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-26

8. AGE: Years

47

Months

8

Days

8

If less than one day

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Unemployed

FATHER

12. Name

Jarome Dougherity (L)

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Kate (L)

15. Birthplace

Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(- RECORDS)

17 (a)

Burial

(Burial, cremation, or entombment)

(b) Date thereof Sept 22, 1943

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

William Cook, Inc.

(b) Address

1217 St. Paul St

SEP 20 1943

VS 180

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1612 W. Fayette St.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-18

1943, at 3:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1939 to 9-18 1943, and that I last saw him alive on 9-18 1943.

Immediate cause of death

Ca of Atherosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Hark

Address

Baltimore

Date signed 9-18-43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08298
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2650 Osage Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Leonard B. Nolley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Emily Nolley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 22 - 1872

8. AGE:

Years

Months

Days

If less than one day

71

6

27

hr.

min.

9. Birthplace

Baltimore, Md.

(town, county, and state)

10. Usual Occupation

Safeguard

11. Industry or business

Insurance

FATHER

12. Name

Marcellus J. Nolley

13. Birthplace

N.C.

MOTHER

14. Maiden Name

Edna E. Sherman

15. Birthplace

Baltimore, Md.

16 (a) Informant

Leonard B. Nolley

(b) Address

1427 Park Ave.

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Baltimore, Md.

18 (a) Funeral director

Callie S. White

(b) Address

2840 Cold Spring Lane

SEP 20 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2650 Osage Ave

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 18, 1943, 8 P - M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15, 1943, to Sept 18, 1943, and that I last saw him alive on Sept 18, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

2 hrs

Due to

Cardiac

Due to

General Arteriosclerosis

Due to

General Arteriosclerosis

Other Conditions

Other Conditions

Other Conditions

Other Conditions

Other Conditions

Other Conditions

Other Conditions

Other Conditions

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Other Conditions

Other Conditions

Other Conditions

Other Conditions

Other Conditions

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

James E. Ashurst

Address

22 Park Heights Ave

Date signed

9-19-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PURSE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08299
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland *Belhogen + Fayette St.*
(b) Street address *Franklin Sq. Hosp.*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 hrs*
(e) Length of stay in Baltimore (yrs., mos., or days) *2 hrs*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1421 N. Fulton Ave.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Baby Girl Apple*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *S.*

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *9-17-43*

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name *Charles*
13. Birthplace *M.*
MOTHER
14. Maiden Name *Crain*
15. Birthplace *Md.*

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location *UNIVERSITY MEDICAL SCHOOL SEP 18 1943*

18 (a) Funeral director *Commissioner of Health*
(b) Address
SEP 20 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 17, 1943, at 7:10 a.m.*
21. I certify that death occurred on the date above stated; that I attended deceased from *9/17 1943* to *9/17 1943*, and that I last saw her alive on *9/17 1943*.
Immediate cause of death

Prematurity
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature *Oscar Hartman*
Address *2231 Eutaw Place* Date signed *9/17/43*

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 08300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08300
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Boy Jester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-2-43

8. AGE: Years

Months

Days

If less than one day

12

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Robert Jester

13. Birthplace

14. Maiden Name

Marion

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

JOHNS HOPKINS MEDICAL SCHOOL SEP 18 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

Huntington Williams, M.D.**SEP 18 1943**

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1319 W Fayette**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 14 1943** at **9:15 P**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 14 1943** to **Sept 14 1943** and that I last saw him alive on **Sept 14 1943**.

Immediate cause of death

Due to **Myocardial Infarction**Due to **Pneumonia**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Chas. Reynolds**Address **Johns Hopkins Hospital**

V8 180

0374

G 08301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX ✓ G 08301
Registered No.

159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Kendall Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Infant Keating

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-4-43

8. AGE: Years Months Days

If less than one day

9

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name

William Keating

13. Birthplace

Towson, Md.

14. Maiden Name

Mary Keating

15. Birthplace

Luttrell, Md.

16 (a) Informant

Mary Keating

(b) Address

1415 Railroad Ave

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 18 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19

(Date rec'd by registrar)

SEP 20 1943 Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1415 Railroad Ave

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 13 1943. 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1943. to 19

and that I last saw her alive on Sept 9 1943

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

Disorder of the

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Carson Johnson

Address President Hospital

Date signed 9/17/43

Duration

9 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08302

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08302
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 20 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1943, at M

21. I certify that death occurred on the date above stated; that I attended
deceased from 9-12 1943 to 9-13 1943
and that I last saw him alive on 9-12 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08303

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)

(d) Street No. _____
(If rural give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Baby Boy Byer

3 (b) If veteran, name war

3 (c) Social Security Account No. _____

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

Black

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 8-21-43

8. AGE: Years

Months

Days

If less than one day

5

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

Catherine Johnson

Md.

16 (a) Informant

Rosa

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

JOHN HOPKINS MEDICAL SCHOOL SEP 16 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 16 1943 Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1943 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1943 to Aug 26 1943 and that I last saw him live on Aug 26 1943.

Immediate cause of death

Atalectasis

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury

23. Signature

Address

C. W. Randel

John Hopkin Hosp.

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PRINTED IN PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08304
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital 76

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Anthony J. Di Marino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 20, 1943

8. AGE: Years

Months

Days

If less than one day

3

2

28

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Joseph J. Di Marino

13. Birthplace

Balti. Md.

14. Maiden Name

Marie Supino

15. Birthplace

New York

16 (a) Informant

Joseph J. Di Marino

(b) Address

416 Oldham St.

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

Sept 20, 1943

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

Wendell J. Hynd

(b) Address

312 S. Highland Ave

19 (a) SEP 20 1943

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

416

Oldham St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 18

1943, 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1943 to Sept. 18, 1943, and that I last saw him alive on Sept. 18, 1943.

Immediate cause of death

Platties of Infancy

Duration

Due to

Due to

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature William H. Lusting
Address St. Joseph's Hosp. Date signed 19-11-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08305
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1533 W. Fairmount Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 90/9

(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1533 W. Fairmount Ave

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Alberta Elizabeth Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27 1883

8. AGE: Years 70 Months 5 Days 21 20 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name Phyllis Owens

15. Birthplace 1 Md

16 (a) Informant Genera Brown

(b) Address 1533 W. Fairmount Ave

17 (a) Burial (b) Date thereof 9 20 43 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co.

18 (a) Funeral director Payer Sanders

(b) Address 1414 E. Preston St

19 (a) SEP 20 1943 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17/43 at 2 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 20 1943 to Sept 17 1943, and that I last saw her alive on Sept 17 1943.

Immediate cause of death Cancer of Uterus

Due to Broken Compensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Williams, M.D.

Address 1728 Pa. Ave Date signed 9/22/43

Duration 1/20/43

7/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08306

BALTIMORE CITY HEALTH DEPARTMENT

MJ-83211

CERTIFICATE OF DEATH

G 08306

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4240 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mo., or days) 1 mo 5 days

(e) Length of stay in Baltimore (yrs., mo., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1045 Lanyale St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Julia Wilson

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife William Wilson (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1875

8. AGE: Years Months Days If less than one day

68

2

14

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Perry Johnson

13. Birthplace Maryland

14. Maiden Name Charollette Stanbury

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 9-21-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore Md.

18 (a) Funeral director Mrs. Francis A. Hempley

(b) Address 578 W. Biddle St.

SEP 20 1943

YB 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1943 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1943 to 9-18 1943.

and that I last saw her alive on 9-18 1943.

Immediate cause of death

Hypertension C-V disease
to decompensation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul R. M.

Address BCI

Date signed 9/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08307

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2643 Harlem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2643 Harlem Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Walter C. Rodis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced. Widower6 (b) Name of husband or wife Daisy Rodis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/1885

8. AGE:

Years

Months

Days

If less than one day

58010

hr.

min.

9. Birthplace Stillwater, Pa.

(Town, county, and state)

10. Usual Occupation Maintenance11. Industry or business Washinghouse Etc. Co.

FATHER

12. Name Simon E. Rodis13. Birthplace SWEDEN14. Maiden Name Rebecca Vaughn15. Birthplace Slatersville, New Kent Co.16 (a) Informant Mrs. Edna E. Beckley(b) Address 2643 Harlem Ave.17 (a) Burial (b) Date thereof 9/22/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory LorraineLocation BALTO., MD.18 (a) Funeral director H. M. J. Tiekner & Son(b) Address North I Penn. Ave.19 (a) SEP 20 1943 (b) Huntington Williams
(Dated by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1943 at 5:00 A.M.21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature Joseph B. McNally, M.D.Date signed 9/20/43 Medical Examiner.

G 08308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08308

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 500 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM L. C. ROBIER

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Pauline E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1867

8. AGE: Years 76 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business Own

12. Name Thomas Robier

13. Birthplace Md.

14. Maiden Name Hanna Parrott

15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Pauline E. Robier

(b) Address 500 N. Fulton Ave.

17 (a) Burial (b) Date thereof 9/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Audon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (b) *Huntington Williams*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1943 until Sept 18, 1943, and that I last saw him alive on Sept. 16, 1943.

Immediate cause of death

Coronary occlusion -

Due to General Arteriosclerosis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *Howard H. Warner*
Address 2404 Garrison Blvd Date signed Sept 18, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

The correct age is especially important. Every item of information should be carefully spelled. Physicians: please write the causes of death clearly and legibly.

SEP 20 1943

Caution: When Filling, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08309
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Methodist Home of the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Emma Barry

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Widow

6 (b) Name of husband or wife Harry S. Barry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1868

8. AGE:

Years

Months

Days

If less than one day

75

3

15

hr.

min.

9. Birthplace Ellicott City, Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name Harvey Chandler

13. Birthplace Bronx Co. N.Y.

14. Maiden Name Eliza Isaac

15. Birthplace Ellicott City, Md.

16 (a) Informant Miss. A. I. Savage Asst. Supt.

(b) Address 2211 W. Rogers Ave.

17 (a) Burial

(b) Date thereof 9/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine Park Cemy.

Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1941, to SEPT. 16, 1943, and that I last saw him alive on SEPT. 16, 1943.

Immediate cause of death

Carcinoma of liver

Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Arthur J. Davis

Address 800 W. 33rd. St.

Date signed 9-18-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 20 1943

G 08310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08310

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *DOA*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *920 N. Wolfe St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROY MASSENBURG Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 24, 1943

8. AGE:

Years

Months

Days

*Less than one day**43**23*

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Roy Massenburg Sr.

13. Birthplace

N. Carolina

14. Maiden Name

Lillie Mae Davis

15. Birthplace

Balto. Md.

16 (a) Informant

Lillie Mae Massenburg

(b) Address

925 N. Wolfe St

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept 20, 1943

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cemetery

Location

Q. Q. County, Md.

18 (a) Funeral director

Mrs. R. G. Elliott & Druggs

(b) Address

1129 N. Carolina St.

19 SEP 20 1943

(Date of death)

Registrar

William H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 17, 1943, at 3:50 P.M.*21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Asphyxiation

Due to

Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *9-17-43* at *7/4* M.(b) Where did injury occur? *home*(c) Did injury occur at home, on farm, industrial place, in public
place? *home* While at work?(d) Means of injury *aspiration of vomitus*23. Signature *H. L. Williams, M.D.*Date signed *9-18-43*

G 08311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08311
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address 107 W. Clement St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 107 W. Clement St
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Ferdinand Frederick

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife.

Katie Prinz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 12, 1866

8. AGE:

Years

Months

Days

If less than one day

7787

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

retired Police Clerk

11. Industry or business

FATHER
MOTHER

12. Name

Ferdinand F. Prinz

13. Birthplace

Germany

14. Maiden Name

Dora Kneue

15. Birthplace

Germany

16 (a) Informant

Ferdinand F. Prinz Jr

(b) Address

310 E-33rd St

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Sept 22, 1943
(month) (day) (year)

(c) Cemetery or crematory

Lorraine Elm

Location

Md

18 (a) Funeral director

W. Howard Evans

(b) Address

1400 S Charles St

19

SEP 20 1943

(b) Wm. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1943, at 3 ¹⁵ P M

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

Autopsy Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Arterioscleroticcardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed

Sept. 19 1943

G 08312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08312

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.*(b) County *Px. George's*(c) City or town *Laurel*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Crofton Calver*

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Cordie Rentroe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1916

8. AGE:

Years

Months

Days

If less than one day

27

hr.

min.

9. Birthplace

Texas
(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

B & O

12. Name

Alan Rentroe

13. Birthplace

Texas

14. Maiden Name

Bessie T. Rammer

15. Birthplace

Texas

16 (a) Informant

Cordie Rentroe

(b) Address

Crofton Calver Laurel, Md.

17 (a)

Removal
(Burial, cremation, or removal)

(b) Date thereof

9/21/43
(month) (day) (year)

(c) Cemetery or crematory

Location

Denison, Tex.

18 (a) Funeral director

Ridgeley Selby

(b) Address

401 Washington Blvd.

19 (a)

(b)

Laurel, Md.

(Date rec'd by registrar)

Registrar

SEP 20 1943 *Huntington Williams, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9/19*19 *43* at *9:30 PM*21. I certify that death occurred on the date above stated, that I attended deceased from *9/19* 19 *43* to *9/19* 19 *43*, and that I last saw him alive on *9/19* 19 *43*

Immediate cause of death

Asphyxia

Due to

Aspiration of vomitus

Due to

Paralytic ileus

Other Conditions

Gastritis of spinal cord - Thoracic
(Include pregnancy within 3 months of death)

Date of operation

9/16/43

Major findings of operations

Gastritis of thoracic cord

of autopsy

No autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

A. A. Registrar

Address

*University Hospital*Date signed *9/21/43*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

08313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08313
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Callow Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Callow Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME
MINNIE W. LISSBERGER.
3 (b) If veteran, name war

3 (c) Social Security Account
No. None
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Albert Lissberger, Sr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 24, 1881.
8. AGE: Years 62 Months 1 Days 28 1/2 hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business
12. Name Levi Wheatfield,
13. Birthplace Balto. Md.
14. Maiden Name Helene Goldsmith,
15. Birthplace Germany.
16 (a) Informant Mr. Albert Lissberger,
(b) Address 2420 Callow Ave.
17 (a) Burial (b) Date thereof 9/21/43.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.
18 (a) Funeral dir. David Sonenshein, Son
(b) Address 1902 Eutaw Place.
19 (a) (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept. 19, 1943 at 4 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Sept. 17, 1943, and that I last saw him alive on Sept. 17, 1943.
Immediate cause of death
General carcinomatous
Due to
Carcinoma of gall bladder 1 yr
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation May 9, 1942
Major findings of operation Carcinoma of gall bladder
of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frederick Lutz M.D.
Address Temple Garden Apts Date signed 9/19/43

Duration
6 mos
PHYSICIAN
Underline the cause to which death should be charged statistically.

SEP 20 1943

Frederick Lutz

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08314

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 829 Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 829 Lexington St.

(If rural give location) (e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1903

8. AGE: Years 40 Months Days If less than one day hr. min.

9. Birthplace Educator N.C.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name William Simpkins

13. Birthplace N.C.

14. Maiden Name Sullivan?

15. Birthplace N.C.

16 (a) Informant Emma Stale

(b) Address 917 Bennett Place

17 (a) Burial (b) Date thereof Sept 20 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (b) Registrar

VB 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1943. at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 to 9/17 1943 and that I last saw him alive on 9/17/43

Immediate cause of death

Acute Myocarditis 7 days

Due to Chronic Nephritis 1 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. T. Gunn M. D.

Address 2221 Lexington Ave. Date signed 9/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08315

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Woman's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Carroll*(c) City or town *Finksburg*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Alice R. Sprinkel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Buck Sprinkel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1914

8. AGE: Years Months Days If less than one day

28 9 26 25 hr. min.

9. Birthplace

Carroll Co.

(Town, county, and state)

10. Usual Occupation

Clothing Factory

11. Industry or business

12. Name

Nicholas Lloyd

13. Birthplace

Md.

14. Maiden Name

Annie Bloom

15. Birthplace

Md.

16 (a) Informant

Mrs. Swann

(b) Address

Finksburg

17 (a) Burial (b) Date thereof

9-23-43

(c) Cemetery or crematory

Finksburg Cem.

Location

Carroll Co.

18 (a) Funeral director

J. F. Elmer, Son

(b) Address

Pikesville Md.

19 (a) (b) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 9, 1943, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Mercury poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Sept 18, 1943

M.

(b) Where did injury occur?

Finksburg, Md.

(c) Did injury occur at home, on farm, industrial place, in public place?

Home

While at work? No

(d) Means of injury

unknown

23. Signature

Robert Lee Graham

M.D.

Date signed

Sept. 20 1943

SEP 20 1943

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08316

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 da

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 931 Peach St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Young

83006

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
male

5. Color or race
black

6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1890

8. AGE: Years Months Days If less than one day
52 30 11 11 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arthur Young
13. Birthplace Va.

MOTHER 14. Maiden Name Mandy
15. Birthplace

16 (a) Informant Hospital records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 20 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Social R Brown Son
(b) Address 108 W Monte Carey St

SEP 20 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 19 43 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 3 1943 to Sept. 15 19 43,
and that I last saw him alive on Sept. 15 19 43.

Immediate cause of death

Pulmonary tuberculosis

Duration

7 mos 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Zugman

Address B. C. H.

Date signed 9/17

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 08317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08317

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address: Wymen Park Drive and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital Baltimore, Md. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Maryland (b) County: Anne Arundel
(c) City or town: Brooklyn, Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4302 South 4th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: _____

3 (a) FULL NAME

THOMAS LEE CLAYTOR

3 (b) If veteran, name war
WW

3 (c) Social Security Account
No.

4. Sex
MALE

5. Color or race
WHITE

6 (a) Single, married, widowed, or
divorced. MARRIED

6 (b) Name of husband or wife: MINNIE GROTHE

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1893

8. AGE: Years 50 Months 7 Days 4
If less than one day
hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Motorman-Street Car

11. Industry or business: United Street Cars-2 Yrs. a

12. Name: James S. Claytor

13. Birthplace: Richmond, Va.

14. Maiden Name: Margaret M. Spruel

15. Birthplace: Richmond, Virginia

16 (a) Informant: Records-US Marine Hospital

(b) Address: Baltimore, Md.

17 (a) Burial (b) Date thereof: Sept 21-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: U.S. Nat. Cemetery
Location: Frederick Rd

18 (a) Funeral director: William M. March

(b) Address: 715 1st St

EP 20 1943 (Date filed by registrar)

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18, 1943, 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1943, to Sept. 18, 1943, and that I last saw him alive on Sept. 18, 1943.

Immediate cause of death:
Weil's Disease

Duration
3 wks.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operations:

of autopsy: AS ABOVE

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: J. C. C. C.

Address: US Marine Hospital
Baltimore, Md.

Date signed: 9/18/43

The
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1335 Sargent St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country.

3 (a) FULL NAME

CLIFTON S. BURTON

3 (b) If veteran, name war

Sp. American

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mollie ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1874

8. AGE: Years Months Days If less than one day

69

6

24 23

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Unk. ?

13. Birthplace ?

14. Maiden Name Unk. ?

15. Birthplace ?

16 (a) Informant Records, U. S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) *Funeral* (b) Date thereof 9/22/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *National*

Location *Baltimore*

18 (a) Funeral director *William H. Williams*

(b) Address *2170 1st Ave*

(Date rec'd by *William H. Williams*)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 18, 1943, at 10:38M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1943 to Sept. 18, 1943, and that I last saw him alive on Sept. 18, 1943.

Immediate cause of death Combined nephrosclerosis and Hydronephrosis

Duration Unk.

Due to

Due to

Other Conditions Hypertrophy of Prostate

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Clifton S. Burton*

Address Baltimore, Md.

Date signed 9/20/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08319

1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Madison St.*
(b) Street address *1212* ~~Madison St.~~
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles Chase

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife

Ema

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1875

8. AGE: Years

68

Months

Days

If less than one day

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

MOTHER / FATHER

12. Name *John Chase*

13. Birthplace

Md.

14. Maiden Name

Henrietta Reed

15. Birthplace

Md.

16 (a) Informant *Alphonsus Chase*

(b) Address *1615 Abbott St.*

17 (a) *Burial*

(b) Date thereof

9/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Elroy O. Wilson

(b) Address

1000 Brantley Ave.

SEP 20 1943 *William M. P.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County

(c) City or town *Baltimore*

(If outside city or town, give street, city, and give town)

(d) Street No. *1212*

Madison St. Madison St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

20. DATE OF DEATH

Sept 18 1943 B.H.
Sept 18 1943 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended
deceased from *Sept 2 1943* to *Sept 18 1943*
and that I last saw him alive on *Sept 18 1943*

Immediate cause of death

Cardio-renal Disease

Duration

?

Due to

Due to

Other Conditions

Total blindness

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? *While at work?*

(Specify type of place)

(e) Means of injury

23. Signature

William M. P.

Address

12074 Columbia

Date signed

M. D.

9/20/43

G 08320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08320

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Balti. City Harbor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph Albert De Frank

3 (b) If veteran, name war

3 (c) Social Security Account
No. *216-10-7483*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE:

Years

Months

Days

If less than one day

34

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

FATHER
MOTHER

12. Name

Leonard De Frank

13. Birthplace

Italy

14. Maiden Name

unknown

15. Birthplace

16 (a) Informant

Anthony Tony De Frank

(b) Address

2612 W. Hudson St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

Dundalk & Greenbelt Rd.

18 (a) Funeral director

Stephen J. Fiedkowski

(b) Address

1000 W. Kensington Ave.

19 (a)

(Date rec'd by registrar)

William Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2727 W. Hudson St.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9-19-1943 at 7:20 A.M.*21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased cameto *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *9-15-43* at*2:05 A.M.*

(b) Where did injury occur?

Off 7 ft 9 in. Forest Path(c) Did injury occur at home, on farm, industrial place, in public
place? *Public* While at work? *No*(d) Means of injury *Fell off ladder. S.S. Benj. Holt.*

23. Signature

Howard J. Thalhiser

M.D.

Date signed *9-19-43*

Medical Examiner.

P 2101012

G 08321

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08321

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3609 Ferndale Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3609 Ferndale Ave

(If rural give location)

(e) Citizen of foreign country?

(Voter No)

If yes, name country

3 (a) FULL NAME

Raymond Kieffer Justice

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Ethel T. Justice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1890

8. AGE: Years Months Days If less than one day

5311

hr.

min.

9. Birthplace Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation

Barber

11. Industry or business

12. Name John S. Justice13. Birthplace Baltimore Co. Md14. Maiden Name Adella M. Kieffer15. Birthplace Baltimore Co. Md.16 (a) Informant Ethel T. Justice(b) Address 3609 Ferndale Ave17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept 21 1943

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Woodlawn Md

18 (a) Funeral director

(b) Address 4204 Ridgewood Ave19 (a) SEP 20 1943

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1943 at 6 M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Sept 19 1943, and that I last saw him alive on Sept 18 1943.

Immediate cause of death

Carcinoma of Brain & metastases
Old injury to eye

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 4Major findings of operation: Removal of adenoma
of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

A. C. Smith

M. D.

Address

509 E. 1st St.Date signed 6-15-43

Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08322

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2206 Roslyn Ave

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2206 Roslyn Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Edith

Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 18-1868

8. AGE: Years Months Days If less than one day

75

3

21

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Richard Sewell Jr

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Emily E. Walker

15. Birthplace

Balto. Md.

16 (a) Informant

Herbert B. Sewell

(b) Address

3411 Bateman Ave

17 (a)

Burial

(b) Date thereof

Sept 22-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto. Md.

(a) Funeral director

Ellsworth Armacost

(b) Address

11 Liberty Heights Ave

19 (a)

(Date rec'd by registrar)

H. M. K. M. K.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1943, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest, multiple lacerations

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 19 1943 5 P.M.

(b) Where did injury occur? Univ. Pharmacy Overlook

(c) Did injury occur at home, on farm, industrial place, in public place? street car tracks While at work? No

(d) Means of injury Struck by street car

23. Signature R. O. G. M. D. Medical Examiner

Date signed Sept. 19 1943.

G 08323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08323

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore Co.(c) City or town Raspburg
(If outside city or town limits, write RURAL and give town)(d) Street No. Elina Avenue
(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

SPARR, Marjorie (MARJORIE SPARR)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 8, 19398. AGE: Years Months Days If less than one day
4 6 11 hr. min.9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation child

11. Industry or business

12. Name LeRoy Sparr13. Birthplace Baltimore14. Maiden Name Anna Raver15. Birthplace Baltimore16 (a) Informant Hospital records

(b) Address

17 (a) Burial (b) Date thereof 9/21/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.18 (a) Funeral director Therese Funeral Home(b) Address 7401 Belair Road19 (a) SEP 30 1943 Washington William

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1943, at 8⁰⁰ P. M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept 14, 1943, to Sept 19, 1943,
and that I last saw h. lx. alive on Sept. 19, 1943.

Immediate cause of death

meningitisDue to meningococcus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. SmithAddress Sydenham Hosp. Date sign

Duration

2 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 08324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08324
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore City.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4670 Park Heights Ave.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. William Walsh. (William Walsh)

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age - Years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1876

8. AGE:

Years 66

Months 11

Days 13

If less than one day

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation retired laundry worker

11. Industry or business

Laundry

FATHER
MOTHER

12. Name Patrick Walsh,

13. Birthplace Ireland

14. Maiden Name Mary Gallagher,

15. Birthplace Ireland

16 (a) Informant Mrs. Delia Foltz.

(b) Address 4670 Park Heights Ave.

17 (a) Burial (b) Date thereof 9/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Baltimore City.

18 (a) Funeral director C. Vernon Lemon.

(b) Address 4611 Park Heights Ave

19 (a)

(Date)

SEP 20 1943

VS

H. H. Williams, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/43 19 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8/6/43 19 to 9/18 1943.
and that I last saw him alive on 9/17/ 1943.

Immediate cause of death

Uremia

Due to

Bilateral Hypertension

Due to

Bilateral Prostatic Hypertrophy

Other Conditions

Renal Calculus
Left Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles P. Drury

M. D.

Address

Bon Secours Hosp

Date signed 9/18/43

G 08325

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08325

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2809 Bayonne Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 27

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)(d) Street No. 2809 Bayonne Ave.
(If rural give location)

(e) If foreign born, how long in U. S. A. ? years

3 (a) FULL NAME

Amanda C. Horsenann

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Adolph C. Horsenann

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1870

8. AGE:

Years

Months

Days

If less than one day

72

8

24

hr.

min.

9. Birthplace

Baltimore City.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

FATHER
MOTHER

12. Name J. Frederick Gross,

13. Birthplace Germany,

14. Maiden Name C. Strauss,

15. Birthplace Germany.

16 (a) Informant Mr. Adolph C. Horsemann,

(b) Address 2809 Bayonne Ave.

17 (a) Burial (b) Date thereof 9/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park,

Location Baltimore City.

18 (a) Funeral director B. Vernon Lamm

(b) Address 4611 Park Heights Blvd.

19 (a) SEP 20 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1943 49 at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/17/1943 to 9/18/1943.
and that I last saw him alive on 9/18/1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

Address 1 W. Overlea Ave. Date signed 9/20/43

G 08326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08326
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caton & Wilkens Ave.*

(c) Hospital or institution:

St. Agnes

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *1 1/2*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 1, 1899

8. AGE: Years

43

Months

109

Days

19

If less than one day

hr.

min.

9. Birthplace

Baltimore Maryland

10. Usual Occupation

Laborer

11. Industry or business

United Distillers Co.

12. Name

Emmer Brandt

13. Birthplace

Germany

14. Maiden Name

Amelia Belins

15. Birthplace

Baltimore

16 (a) Informant

Mrs. William Menke

(b) Address

*1311 Stephens Ave. Arbutus*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematorium

London Park Sept 21/43

Location

Baltimore Md

18 (a) Funeral director

Harry A. Witzke

(b) Address

4101 Edmonson Ave.

19 (a)

(Date rec'd by registrar)

Harry A. Witzke

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3005 Morris St*

(e) Citizen of foreign country? (If rural give location)

If yes, name country.

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 19 1943* at *8:30* M21. I certify that death occurred on the date above stated; that I attended deceased from *9/18 1943* to *9/19 1943*, and that I last saw him alive on *9/19 1943*.Immediate cause of death *Meningococci meningitis*

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address *St. Agnes Hosp*Date signed *9/19/43*

SEP 20 1943

The correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

60823

272

4. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address. 4940 Eastern Avenue

(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County _____
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3873 Woodridge Rd.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------------------------	-----------------------------------

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1942. AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 19 92 to 9/19 19 92 and that I last saw him alive on 9/19 19 92.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operations:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) **Accident, suicide, or homicide.**

7(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____

Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(c) Means of injury

23. Signature Paul Watt

Address B.C. 17

Date signed 9/18/82

6 (b) Name of husband or wife Kathie 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) APR. 1. 1873

8. AGE: Years	Months	Days	If less than one day	
70	5	18 hr. min.

9. Birthplace Mo.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name William F. Eberwein

PA 13. Birthplace Germany

14. Maiden Name Katherine Finkle

15. Birthplace *USA*

16 (g) Informant BALTIMORE CITY HOSPITALS

(b) Address	(RECORDS)
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17 (a) Burial (b) Date thereof Sept 22/4
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ballymore Co.
Location S. North Ave.

18 (a) Funeral director *James W. Campbell*

(b) Address 724 O-20th St

19 (a) SEP 20 1968 *Handwritten: For William H. R.*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08328
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1136 Ridgely St

(c) Hospital or institution:

Balto Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1136 Ridgely St

(If rural give location)

(e) If foreign born, how long in U. S. A. 36 years

3 (a) FULL NAME

Dodo. (Alexander) Iskendarian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/17/1863

8. AGE:

Years

Months

Days

If less than one day

80

1

1

hr.

min.

9. Birthplace

Asia Minor

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

FATHER
MOTHER

12. Name Arabel Iskendarian

13. Birthplace Asia Minor

14. Maiden Name

15. Birthplace

16 (a) Informant Mary Alexander

(b) Address 1136 Ridgely St

17 (a) Burial (b) Date thereof

9 21 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Bel Air Rd.

18 (a) Funeral director Raymond

(b) Address 1402 Eastern Ave Rd

(c) Date for'd by registrar

SEP 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1943 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1943 Sept 18 1943

and that I last saw him alive on Sept 18 1943

Immediate cause of death

Coronary Vascular Disease

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

Duration

1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Edward J. Hula M.D.

Address 600 Wash 18th Date signed 9 20 43

G 08329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08329

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Wilkins & Cator Aves.*
 (c) Hospital or institution: *St. Agnes Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*
 (e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mrs. Lulia Mc Colgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Husband - Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *5-26-78*

8. AGE: Years Months Days If less than one day

65 3 22 hr min

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Andrew J. Fleming

13. Birthplace

Md. Fleming

14. Maiden Name

Amelia Yockel (he)

15. Birthplace

Md.

16 (a) Informant

Arthur J. Mc Colgan Sr.

(b) Address

1921 W. Lombard St.

17 (a) Burial

Funeral

(Burial, cremation, or removal)

(Date thereof)

(b) Date thereof

8/21/43

(c) Cemetery or crematorium

*London Park*Location *Trudys Park*

18 (a) Funeral director

J. M. J. Egan

(b) Address

100 Hollins St.

SEP 20 1943

VS 144

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL, and give town)
 (d) Street No. *1921 W. Lombard St.*
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 18 1943* at *9:30* M21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 13 1943* to *Sept. 18 1943* and that I last saw her alive on *Sept. 18 1943*Immediate cause of death *Meningococcus meningitis*Duration
7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *C. Arthur Rossberg*Address *St. Agnes Hosp.* Date signed *9/20/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

The correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08330
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from to and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

West Baltimore

PHYSICIAN

Underline the cause to which death should be charged statistically.

Address: Baltimore 45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08332

Baltimore City Health Department
CERTIFICATE OF DEATH

Bowie

922

G 08332

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: *Green + Lombard St*
(c) Hospital or institution: *University Hosp.*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *15 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *15 days*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Ind* (b) County *Charles*
(c) City or town *La Plata*
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Mrs. Blanche Beevick*

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *female* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced *widowed*
6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *abt 1886*

8. AGE: Years *57* Months Days If less than one day hr. min.

9. Birthplace *Ind* (Town, county and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Geo. Warner*

13. Birthplace *Ind*

14. Maiden Name *Edwinneth Lyon*

15. Birthplace *Ind*

16 (a) Informant *Wm. Lucille Bowie*

(b) Address *La Plata Ind*

17 (a) *Buried* (b) Date thereof *9-23-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Location *La Plata Ind*

18 (a) Funeral director *Ward + Ryan*

(b) Address *Waldorf Ind*

19. Date of death *SEP 21 1943* by *William N. Williams*

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/20/1943* at *6:30 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/5/1943* to *9/20/1943* and that I last saw *her* alive on *9/20/1943*.

Immediate cause of death *Septicemia*

Due to *Endocarditis*

Due to *Staphylococcus aureus*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: *Enlarged spleen, focal necrosis, abscess of autopsy: *Staphylococcus aureus*, *Endocarditis*, *Septicemia*.*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury *S. L. J. Smith*

23. Signature *S. L. J. Smith*

Address *Univ. Hosp. Redwood + green sts.*

Date signed *9/20/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08333

T.N 75743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08333
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Walter Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

C.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th, 1871

8. AGE: Years Months Days If less than one day

72

2

12

11

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Jim Jordan

13. Birthplace Maryland

14. Maiden Name Mollie Offerd

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 20 1943

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 20 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (Baltimore City Hosp

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1943, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/15 1943 and that I last saw him alive on 9/15 1943.

Immediate cause of death

Pneumonia, left

Duration

Due to

Due to

Other Conditions A-S. C.V. disease
Anemia; cer. thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: anal. found

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Surman

Address B C H

Date signed 9/17

08334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1860 08334
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caroline + Oliver St.*

(c) Hospital or institution:

St. Joseph

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *205 S. Wickham Rd.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

*Widow*6 (b) Name of husband or wife *Late Patrick*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 10, 1867

8. AGE:

Years

Months

Days

If less than one day

*76**4**7*

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Mathew Flynn*13. Birthplace *Ireland*

14. Maiden Name

15. Birthplace *Ireland*16 (a) Informant *Mathew P. Hawkins*(b) Address *205 S. Wickham Rd.*17 (a) *Burial* (b) Date thereof *Sept 21/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *New Cathedral*Location *Baltimore Md.*18 (a) Funeral director *Harry H. Witzke*(b) Address *166 Diamond Ave.**Huntington Williams*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-17 1943 at 10:00 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *8/24 1943* to *9-17 1943*, and that I last saw h.c.k. alive on *9-17 1943*.

Immediate cause of death

*Fracture of Pelvis.*Due to *Fall down flight of stairs.*

Due to

Other Conditions *Generalized Cardiovascular Renal arteriosclerotic Disease.*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide *Accident* *8/6*(b) Date of occurrence *8-29* *M*(c) Where did injury occur? *13th. md.**1724 N. Wolfe St.* City or town (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? *Neighbor's Home* While at work? *No.*

(Specify type of place)

(e) Means of injury *Fall down cellar stairs.*23. Signature *Joseph DeBenedictis*Address *St. Joseph's Hosp.* Date signed *9/22/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

SEP 21 1943

VB 150

H. J. Wolbrosch, M.D. Dist. Medical Examiner

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08335
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1622 N. Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY GIRL DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account
No. --

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/1943

8. AGE: Years Months Days If less than one day
-- -- 1 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business --

12. Name Albert E. Davis

13. Birthplace Balto., Md.

14. Maiden Name Clara M. Scharb

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Albert E. Davis
(b) Address 1622 N. Monroe St.

17 (a) Burial (b) Date thereof 9/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Stone Chapel
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 21 1943 (b) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 19 1943 at 11:00M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1943 to 9/19 1943 and that I last saw him alive on 9/19 1943

Immediate cause of death

Due to *Atelactasis*
Pneumatury

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature *Charles A. Curran* M. D.
Address 2145 W. Balto. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08337

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore Gen'l Hosp. 204

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2553 Edmondson Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lena LavaniaBecker3 (b) If veteran, name war
no3 (c) Social Security Account
No. none

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 18888. AGE: Years 55 Months 4 Days 24 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation housewife

11. Industry or business

12. Name Theodore Sturn13. Birthplace Balto.14. Maiden Name Louisa Watts15. Birthplace Balto.16 (a) Informant Mr. William A. Becker(b) Address 2553 Edmondson Ave.17 (a) Burial (b) Date thereof 9/23/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon Park Cem.Location Balto., Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19 SEP 21 1943 (Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1943 at 5³⁰ A.M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☐, suicide ☒,
homicide ☐, undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury Sept. 20 1943 M.(b) Where did injury occur? 2553 Edmondson Ave.(c) Did injury occur at home, on farm, industrial place, in public
place? street While at work? no(d) Means of injury Jumped out of window23. Signature Robert Lee Shattuck M.D.Date signed Sept. 20 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G 08238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08338

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date there

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1943, to Sept 20 1943, and that I last saw him alive on Sept 19 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 21 1943

G 08339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08339
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 9. 9.(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.(b) County BALTO.(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2815 Mayfield Ave

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas L.Ramsay

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

M

5. Color or race

N.

6 (a) Single, married, widowed, or divorced.

MARRIED6 (b) Name of husband or wife ROSE M. RAMSAY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 17 1902

8. AGE: Years Months Days If less than one day

40 10 3 hr. min.9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation POLICE OFFICER11. Industry or business BALTO. CITY POLICE DEPT.12. Name THOMAS L. RAMSAY13. Birthplace BALTO. MD.14. Maiden Name MARIA WOODS15. Birthplace BALTO. MD.16 (a) Informant ROSE M. RAMSAY (WIFE)(b) Address 2815 MAYFIELD AVE.17 (a) BURIAL (b) Date thereof SEPT. 23/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory HOLY REDEEMERLocation BELAIR ROAD18 (a) Funeral director Lilly and Geisler N.C.(b) Address 403 S. WOLFE ST.19 (a) SEP 21 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1943, at 9 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Bullet woundof head.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept. 20 1943 A.M.(b) Where did injury occur? ST. VINCENT'S Cemetery, Belair Road

(c) Did injury occur at home, on farm, industrial place, in public

place? Cemetery While at work? no(d) Means of injury Shot off with pistol23. Signature Robert E. Frater, M.D.

Medical Examiner.

Date signed Sept. 20 1943

G 08340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days) ?

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife UNKNOWN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

50+

hr. min.

9. Birthplace UNKNOWN

(Town, county, and state)

10. Usual Occupation SEA MAN

11. Industry or business

FATHER
MOTHER

12. Name UNKNOWN

13. Birthplace ?

14. Maiden Name UNKNOWN

15. Birthplace ?

16 (a) Informant CITY MOURGE

(b) Address RECORDS

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof SEPT. 21/43

(month) (day) (year)

(c) Cemetery or crematory ST. MATTHEWS

Location O'DONNELL ST.

18 (a) Funeral director Lilly and Zeller INC.

(b) Address 403 S. WOLFE ST.

19 (a) SEP 21 1943

(b) Date of death

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1416 N. 14th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-1943 at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions Multiple lacerations,

abrasions & bruises.

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-15-43

(b) Where did injury occur? Office - Alhambra St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Blunt force

23. Signature Howard J. Mueser M.D.

Medical Examiner.

Date signed 9-16-43

Registrar
H. M. Williams, M.D.

G 08341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08341
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3517 CHESTERFIELD AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 3517 CHESTERFIELD AVE.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MICHAEL KUTRIK

3 (b) If veteran, name war

W.W. 1

3 (c) Social Security Account

No 212-09 7161

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife BERTHA KUTRIK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 14 1899

8. AGE: Years Months Days If less than one day
44 1 5 hr. min.

9. Birthplace BALTO. MD.

(Town, county, and state)

10. Usual Occupation WATCHMAN

11. Industry or business FRANKFORT DIS.

12. Name DANIEL KUTRIK

13. Birthplace RUSSIA

14. Maiden Name THERESA KANINSKI

15. Birthplace POLAND

16 (a) Informant SAMUEL KUTRIK (SON)

(b) Address 3517 CHESTERFIELD AVE

17 (a) BURIAL (b) Date thereof SEPT. 22/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Geller INC.

(b) Address 403 S. WOLFE ST.

19 (a) SEP 21 1943

VB 100

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH SEPT. 19 19 43 3/28M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1943 to Sept 19 1943 and that I last saw him alive on Sept 19 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

Due to

Hypertension

Due to

Chronic nephritis

Other Conditions

Arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Crater & Anderson

Address 300 (Shannon) Date signed 9/20/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Amos Williams M.D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 08343

G 08343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 Cleveland ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Eliza Ford(a) RESIDENCE. No. 1246 Cleveland ST., 18 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

James T. Ford
Aug 3 1850

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 93 Months 1 Days 17 If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cambridge
Maryland

10 NAME OF FATHER

Allison Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cambridge
Maryland

12 MAIDEN NAME OF MOTHER

Eliza J. Pritchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge
Maryland

14

Informant (Address)

Mrs. Bertha Korder
1246 Cleveland St. Baltimore

15

SEP 21 1943

Huntington Williams
W. Pippin

MEDICAL CERTIFICATE OF DEATH

14 DATE OF DEATH (month, day, and year) Sept. 20, 1943

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1937, to Sept. 20, 1943.that I last saw her alive on Sept. 20, 1943.and that death occurred, on the date stated above, at 10.00 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis(duration) 7 yrs. mos. ds.CONTRIBUTORY Atherosclerosis

(Secondary)

(duration) 10 yrs. mos. ds.

16 Where was disease contracted

If not at place of death? At place of deathDid an operation precede death? No Date of NoneWas there an autopsy? NoWhat test confirmed diagnosis Clinical symptoms

(Signed)

Frank H. Oyster M. D.Address: 2701 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Elkton

DATE OF BURIAL

Sept 23 1943

20 UNDERTAKER

ADDRESS

G 08344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08344
Registered No.

The correct age is especially important. Every item of information should be carefully supplied. The cause of death should be clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(q) State

(r) City or town

(s) Street No.

(t) Citizen of foreign country?

(u) If yes, name country

(v) If rural give location

(w) If yes, name country

(x) If yes, name country

(y) If yes, name country

(z) If yes, name country

(aa) If yes, name country

(ab) If yes, name country

(ac) If yes, name country

(ad) If yes, name country

(ae) If yes, name country

(af) If yes, name country

(ag) If yes, name country

(ah) If yes, name country

(ai) If yes, name country

(aj) If yes, name country

(ak) If yes, name country

(al) If yes, name country

(am) If yes, name country

(an) If yes, name country

(ao) If yes, name country

(ap) If yes, name country

(aq) If yes, name country

(ar) If yes, name country

(as) If yes, name country

(at) If yes, name country

(au) If yes, name country

(av) If yes, name country

(aw) If yes, name country

(ax) If yes, name country

(ay) If yes, name country

(az) If yes, name country

(ba) If yes, name country

(bb) If yes, name country

(bc) If yes, name country

(bd) If yes, name country

(be) If yes, name country

(bf) If yes, name country

(bg) If yes, name country

(bh) If yes, name country

(bi) If yes, name country

(bj) If yes, name country

(bk) If yes, name country

(bl) If yes, name country

(bm) If yes, name country

(bn) If yes, name country

(bo) If yes, name country

(bp) If yes, name country

(bq) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 day

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

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1 yr. +

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1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

1 yr. +

G 08345

AB-83811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08345

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 4940 EASTERN AVE.
 (c) Hospital or institution:
Baltimore City Hospitals
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
 (e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 826 S. East Ave.
 (If rural give location)
 (e) Citizen of foreign country? ? (Yes or No)
 If yes, name country ?

3 (a) FULL NAME

ALIX-OR Alexander Melnick

3 (b) If veteran, name war

3 (c) Social Security Account
No. ?

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or divorced.
Separated6 (b) Name of husband or wife Bertha6 (c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) 9-9-9 (?)

8. AGE: Years

?

Months

?

Days

?

If less than one day

? hr.? min.9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
MOTHER12. Name John Melnick13. Birthplace Russia14. Maiden Name Bertha15. Birthplace ?16 (a) Informant Baltimore City Hospitals(b) Address Records17 (a) Burial (b) Date thereof Sept. 12-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Trinity RussianLocation Angels Grounds, County18 (a) Funeral director John G. [illegible](b) Address 423 S. Park St.19 (a) SEP 21 1943 (b) ?

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1943, at 6:00 PM21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1943, to 9-18 1943, and that I last saw him alive on 9-18 1943.

Immediate cause of death

Pneumonia

Duration

?Due to Pulmonary Tuberculosis?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As cause

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ? at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul MaltAddress RCRDate signed 9/19/43

Address 2111 12th Ave Date signed 7-21-46

Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

08347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08347
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3512 Lyndale

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3512 Lyndale Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna Marie Timmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1883

8. AGE: Years 59 Months 8 Days 27 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

12. Name Conrad Bierau

13. Birthplace Germany

14. Maiden Name Don't know

15. Birthplace Germany

16 (a) Informant Muriel S. Timmons

(b) Address 3512 Lyndale Ave

17 (a) Burial (b) Date thereof Sept 21, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Balto Co Md

18 (a) Funeral director William Funeral Home

(b) Address 2008 Orleans St

19 (a) SEP 21 1943
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1943 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1943, to Sept 18 1943 and that I last saw him alive on Sept 17, 1943

Immediate cause of death

Coronary artery

Due to Myocardial infarction

Due to Long standing

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. J. Timmons

Address 6774 Madison Date signed 9/19/43

Duration

4 min

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08348 HEALTH DEPARTMENT—CITY OF BALTIMORE 08348

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Grace Court, 25-5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mod. 7 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. 329 S. Market St. Frederick Md

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced HUSBAND of Lewis Motley (or) WIFE of

6. DATE OF BIRTH (month, day, year) December 12, 1880

7. AGE Years 62 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Frederick County Maryland (State or country)

13. NAME Eli Wolfe

14. BIRTHPLACE (city or town) Frederick County Maryland (State or country)

15. MAIDEN NAME Susan B. Age

16. BIRTHPLACE (city or town) Frederick County Maryland (State or country)

17. INFORMANT Lewis Motley (Address) 329 S. Market St. Frederick Md

18. BURIAL, CREMATION, OR REMOVAL Place Not at Church of Frederick Md Date 9/24, 1943

19. UNDERTAKER M. R. Elchman (Address) Frederick Md

20. SEP 21 1943 19. Huntington, Md

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 21, 1943

22. I HEREBY CERTIFY, That I attended deceased from 9/20/43, 19 to 9/21/43, 19

I last saw him alive on 9/21, 1943 Death is said to have occurred on the date stated above, at 6:30 a.m.

The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public

place Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Samuel R. [Signature] M. D.

(Address) 203 B. [Signature]

08349 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

G 08349

PLACE OF DEATH *Volunteers of America Hospital* Registered No. _____
 CITY OF BALTIMORE: (No. *418 W. Lexington St.* Ward *4-1*)
 Length of residence in city or town where death occurred *30* yrs. *0* mos. *0* ds. How long in U. S. If of foreign birth? *0* yrs. *0* mos. *0* ds.
 2. FULL NAME *William C. Pomplon Sr.* If U. S. Veteran specify WAR
 (a) Residence: No. *410 W Fayette* St., Ward *S.S. # 217-12-6451*
 (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX <i>M</i>	4. Color or Race <i>W.</i>	5. Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
6a. If married, widowed, or divorced, HUSBAND of <i>Magdalene Pomplon</i> (or) WIFE of		
6. DATE OF BIRTH (month, day, year) <i>Dec 13 - 1884</i>		
7. AGE <i>58</i>	Years <i>9</i>	Months <i>7</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Bartender</i>		9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>club</i>
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation <i>30 yrs</i>

12. BIRTHPLACE (city or town) (State or country) <i>Germany</i>
13. NAME <i>Karl Pomplon</i>
14. BIRTHPLACE (city or town) (State or country) <i>Germany</i>
15. MAIDEN NAME <i>Unknown</i>
16. BIRTHPLACE (city or town) (State or country) <i>Germany</i>

17. INFORMANT <i>Wm C. Pomplon Jr.</i> (Address) <i>2738 Pelham Ave</i>
18. BURIAL, CREMATION, OR REMOVAL Place <i>Woodlawn</i> Date <i>9/23</i> 19 <i>43</i>
19. UNDERTAKER <i>Philip Hennig Sons</i> (Address) <i>2324 Orleans St</i>

FILED *SEP 21 1943* Registrar. *William C. Pomplon Jr.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) <i>9/20/43</i> , 19 <i>43</i>
22. I HEREBY CERTIFY, That I attended deceased from <i>9/18/43</i> , 19 <i>43</i> , to <i>9/20/43</i> , 19 <i>43</i> . I last saw <i>h.i.m.</i> alive on <i>9/20/43</i> , 19 <i>43</i> . Death is said to have occurred on the date stated above, at <i>7:00 P.M.</i> The principal cause of death and related causes of importance were as follows: <i>Carcinoma of Liver</i> <i>Cardiac Failure</i> <i>Pulmonary Embolism</i> Other contributory causes of importance: Was an operation performed? <i>no</i> Date of _____ For what disease or injury? Name of operation <i>None</i> What test confirmed diagnosis? <i>None</i> Was there an autopsy? <i>no</i> 23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place _____ Manner of injury _____ Nature of injury _____ 24. Was disease or injury in any way related to occupation of deceased? <i>no</i> If so, specify _____ (Signed) <i>Willard Applefield</i> M. D. (Address) <i>2511 Rristown Rd.</i> <i>Balto. Md.</i>

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08350

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Wilkins and Caton Aves*
(c) Hospital or institution: *St. Agnes*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD.* (b) County
(c) City or town *Balto.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *637 Oldham St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

- Gus Chagetas*
3 (b) If veteran, name war 3 (c) Social Security Account
No. *213-09-1474*

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Angelina*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1891*
8. AGE: Years *52* Months Days If less than one day
hr. min.

9. Birthplace *Greene*
(Town, county, and state)

10. Usual Occupation

11. Industry or business *Beth. Steel*

12. Name *Gus Chagetas*
13. Birthplace *Turkey*
14. Maiden Name *Mary Smernick*
15. Birthplace *Turkey*

- 16 (a) Informant *Loretta Mayers*
(b) Address *St. Agnes Hospital*
17 (a) *Funeral* (b) Date thereof *9/21/43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Woodlawn, Co*
Location

- 18 (a) Funeral director *J.A. Shatter*
(b) Address *Westminster, Md.*

- 19 (a) *SEP 21 1943*
(b) Registrar *Harington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/18* 19*43* at *12:30* P.M.
21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *9/15* 19*43* to *9/18* 19*43*,
and that I last saw h/m. alive on *9/18* 19*43*.

Immediate cause of death

- Haemorrhage*
Due to *Probable peptic ulcer*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *none*

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *Howard W. Stier*
Address *St. Agnes Hospital* Date signed *9/18/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08351

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08351

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1166 Washington Blvd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1166 Washington Blvd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Lillian May Smoot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

Married

6 (b) Name of husband or wife. John A. Smoot

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 13, 1894

8. AGE: Years

Months

Days

If less than one day

50

5

5

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

12. Name George Holmes

13. Birthplace Baltimore, Md.

14. Maiden Name Anna Brunn

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John A. Smoot

(b) Address 1166 Washington Blvd.

17 (a) Burial

(b) Date thereof Sept. 22, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium London Park Cemetery

Location

Baltimore, Md.

18 (a) Funeral director

J. L. Amoroso

(b) Address 4510 Liberty Heights Ave.

EP 21-1943

Registrar

H. M. Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1943 at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1943 to Sept. 18 1943, and that I last saw her alive on Sept. 18 1943.

Immediate cause of death

Pulmonary Thrombosis

Due to Pulmonary Thrombosis

Due to (non)

Other Conditions Infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Medical Arts Bldg.

Date signed 9/20/43

M. D.

In case of death, please write the causes of death clearly and legibly.

G 08352 HEALTH DEPARTMENT—CITY OF BALTIMORE 08352

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 3604 Mohawk Ave. St. 1 Ward)

Length of residence in city or town where death occurred 1.5 yrs. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Anna May Engel

(a) Residence: No. 3604 Mohawk Ave. St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced HUSBAND of William H. Engel - 77 years (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 21, 1871

7. AGE Years 72 Months 3 Days 28 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

13. NAME Gilson Warner Metcalfe

14. BIRTHPLACE (city or town) York Springs (State or country) Pennsylvania

15. MAIDEN NAME Sara Colby

16. BIRTHPLACE (city or town) Fayetteville (State or country) Pennsylvania

17. INFORMANT Mr. William H. Engel (Address) 3604 Mohawk Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Woodlawn Cemetery Date Sept. 22, 1943

19. UNDERTAKER 1 1943 (Address) 4510 Liberty Heights Ave.

20. FILED

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) September 19, 1943

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1940 to Sept. 19, 1943. I last saw him alive on August 16, 1943. Death is said to have occurred on the date stated above, at 11:40 A.M.

The principal cause of death and related causes of importance were as follows:

Carcinoma Breast

Date of onset 1930

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so specify

(Signed)

(Address)

M. D.

G 08353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08353
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5412 Catalpha Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

August Guy Huber

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/13/42

8. AGE:

Years

Months

Days

If less than one day

066

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

August C. Huber

13. Birthplace

Baltimore

14. Maiden Name

Steenie M. Furlott

15. Birthplace

Georgia

16 (a) Informant

Mr. A. C. Huber

(b) Address

5412 Catalpha Rd

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

9/21/43
(month) (day) (year)

(c) Cemetery or crematory

Hope Redeemer

Location

Baltimore

18 (a) Funeral director

John J. Lough

(b) Address

1111 Light St.

21 1943

August C. Huber

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5412 Catalpha Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 19

1943

at 3:00 P.M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 21 1943 to Sept 19 1943,
and that I last saw him alive on Sept 19 1943.

Immediate cause of death

Congenital Heart Disease

Duration

Life.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Karl W. EhlingAddress 3311 St. Paul StreetDate signed 9/20/43

G 08354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08354
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 13.4

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind

(b) County Baltimore

(c) City or town Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1701

Augusta Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

ORVAL

SMITH

3 (b) If veteran, name war

3 (c) Social Security Account

No 28409-1753

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Wanda Smith

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 7-25-1906

8. AGE:

Years

Months

Days

If less than one day

37

1

25

hr.

min.

9. Birthplace

West Virginia

(Town, county, and state)

10. Usual Occupation

operator

11. Industry or business

Bethlehem Ship Can

FATHER

12. Name

Loring Smith

13. Birthplace

W. Virginia

MOTHER

14. Maiden Name

Wanda

15. Birthplace

?

16 (a) Informant

Wanda Smith

(b) Address

1901 Augusta Ave Dundalk

17 (a) B.

(Burial, cremation, or removal)

(b) Date thereof 9-23-43

(month) (day) (year)

(c) Cemetery or crematory

Sacred Heart of Mary

Location

Seeman Hill Rd.

18 (a) Funeral director

John J. Hurd

(b) Address

2829 Hudson St

SEP 21 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1943, at 1:30 PM

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-20-43, at 12:20 am

(b) Where did injury occur? above address

(c) Did injury occur at home, on farm, industrial place, in public

place? home While at work? Yes

(d) Means of injury fall off roof while framing

23. Signature H. H. Wallamater M.D.

Date signed 9-21-43

The age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08355

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1151 N. Carrollton ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-20-1891

8. AGE: Years 52 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Powells Point N. C.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

12. Name James Harrison

13. Birthplace N. C.

14. Maiden Name unknown

15. Birthplace

16 (a) Informant Charles White

(b) Address 1151 N. Carrollton ave

17 (a) Burial (b) Date thereof 9-21-43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Hope Park
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna ave

SEP 21 1943

VS 140

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1151 N. Carrollton ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1943 at 8:49 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1943 to 9/21 1943, and that I last saw her alive on 9/20 1943.

Immediate cause of death

Chronic Valvular Heart Disease
Due to Pulmonary Embolism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. A. Jackson M. D.

Address 600 Washington Ave

Duration

3 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Ind.** (b) County
(c) City or town **Balto**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **614 W. Biddle St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Joseph Henry**
3 (b) If veteran, name war **World War I.** 3 (c) Social Security Account No.

4 Sex **Male** 5. Color or race **Col.** 6 (a) Single, married, widowed, or divorced. **Single**
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **9-11-95**
8. AGE: Years **48** Months **-** Days **8** If less than one day hr. min.

9. Birthplace **Georgia**
(Town, county, and state)

10. Usual Occupation **Labourer**
11. Industry or business

FATHER
12. Name
13. Birthplace
MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant **Records -**
(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **9/23/43**
(c) Cemetery or crematory **Balto Nat. Cem.**
Location **Univ. Trupest Co. Rd.**

18 (a) Funeral director **Andrus H. H. H.**
(b) Address **918 Bond St. Balto.**

19 (a) **SEP 21 1943** (b) **Harvey Williams, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 19 1943 at 6¹⁹ P M**
21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 16 1943** to **Sept 19 43** and that I last saw him live on **Sept 19 43**

Immediate cause of death
Tuberculous Meningitis

Duration
3 weeks

Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature **T.B. Schwartz**
Address **Johns Hopkins Hosp** Date signed **9/20/43**

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08357

830

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 527 Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Farmer
3 (b) If veteran, name war 3 (c) Social Security Account No. 219-01-0940
4. Sex m 5. Color or race Col. 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years Months Days If less than one day
61 hr. min.
9. Birthplace South Boston Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace
MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Oliver Bellamy
(b) Address 527 N. Paca St
17 (a) Burial (b) Date thereof 9/23/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Calvary
Location Anne Grundel Co. Trd.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) SEP 21 1943 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept. 20, 1943 at 6:15 P.
21. I certify that death occurred on the date above stated that I attended deceased from Sept 16 1943 to Sept 20 1943 and that I last saw him alive on Sept 20 1943
Immediate cause of death Cerebral Venous Thrombosis
Duration 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [Signature] M. D.
Address [Address] Date signed 9/21/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

8358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08358

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1943

8. AGE: Years Months Days If less than one day

3 wks. hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 21 1943

18 (a) Funeral director Commissioner of Health

(b) Address

Huntington Williams, M.D.

SEP 21 1943 (b) Registrar

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 113 N. Penn St. (If rural give location)

(e) Citizen of foreign country? W. Perry Jr. Yes or No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1943, at 7:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1943 to Sept 19 1943, and that I last saw him alive on Sept 17 1943.

Immediate cause of death

Dysentery of the newborn

Due to

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Providence Hospital Date signed 9-24-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

0385

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08359

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1385 Woodys ST (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 day

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Dewey Hampton

13. Birthplace A.A.C., Md.

14. Maiden Name Victoria Moss

15. Birthplace Raleigh, N.C.

16 (a) Informant

(b) Address

17 (a) (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 21 1943 Huntington Williams, M.D.
(Date rec'd by registrar)

VB 150

0386

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1943 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1943 to Sept 18 1943, and that I last saw him alive on Sept 16 1943.

Immediate cause of death

Rematurity 6 1/2 mm

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G. H. Bayfield

Address Provident Hospital Date signed 9-18-43 M. D.

G 08360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08360
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 3309 Denbush Drive
 (c) Hospital or institution: Sinai Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~Street~~ (b) County
 City or town 3309 Denbush
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. Baltimore
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME ~~John~~ Prender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

Newborn

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 21 1943

18 (a) Funeral director

(b) Address

19

SEP 21 1943

(Date rec'd by registrar)

Commissioner of Health

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 19 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1943 to June 19 1943 and that I last saw him alive on June 19 1943

Immediate cause of death

Respiratory failure

Duration

Due to

incomplete aeration of lungs

Due to

Other Conditions

Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

A. H. Ruskoff

Address

Sinai Hosp

Date signed

9/17/43

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the cause of death clearly and legibly.

8361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08361
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 951 Pennsylvania Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County:(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 951 Pennsylvania
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Edna Lee Mason

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

F

5. Color or race

negro

6 (a) Single, married, widowed, or divorced.

Single6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 19438. AGE: Years Months Days If less than one day
3 hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual Occupation none

11. Industry or business

12. Name Samuel Mason13. Birthplace Frankfort Virginia14. Maiden Name Estelle Bowser15. Birthplace Halifax, N. C.16 (a) Informant Estelle Mason(b) Address 951 Pennsylvania Ave17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 21 194318 (a) Funeral director Commissioner of Health

(b) Address

SEP 21 1943(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1943, at 2:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1943 to Sept 20 1943, and that I last saw her alive on Sept 19, 1943.Immediate cause of death Prematurity.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [Signature]
Address [Address] Date signed 9-20-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

0388

G 08362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08362

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Greene + Redwood

(c) Hospital or institution:

University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

3 (a) FULL NAME

Hannah Mary Treisbach

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

4 Sex

Female

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Norman P. Treisbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 31, 1922

8. AGE: Years

21

Months

3

Days

19

If less than one day

hr.

min.

9. Birthplace

Norristown, Pa.

(Town, county, and state)

10. Usual Occupation

Clerk - Accounting Dept.

11. Industry or business

B & O. R. R.

FATHER

12. Name

Martin J. Gauger

13. Birthplace

Phila., Pa.

MOTHER

14. Maiden Name

Hannah Hardy

15. Birthplace

Berwyn, Pa.

16 (a) Informant

Mr. Martin Gauger

(b) Address

4239 Wickford Rd.

17 (a)

Removal

(b) Date thereof

9/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Norristown, Pa.

18 (a) Funeral director

Wm. J. Tickner & Sons

(b) Address

Balto., Md.

19

SEP 24 1943

(b)

H. B. Hagan

Address

Greene + Redwood

Date signed 9/20/43

2. USUAL RESIDENCE OF DECEASED:

(a) City or town

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4239 Wickford Rd.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 20, 1943, 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1943 to Sept. 20, 1943.

and that I last saw her alive on Sept. 20, 1943.

Immediate cause of death

yellow atrophy of liver
c. hepatic insufficiency

Due to

Due to

Other Conditions

Pleural effusion,
pulmonary edema, ascites,
peritonitis (last 24 hours of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. B. Hagan, M.D.

Address

Greene + Redwood

Date signed 9/20/43

Correct age is especially important. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 08363

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08363

Registered No.

131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 412 Light St.

(c) Hospital or institution:

South Baltimore Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 d.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto City

(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)(d) Street No. 105 W. Hart Ave
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. WAGNER.

3 (b) If veteran, name war

No

3 (c) Social Security Account

No No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Ella M. Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1867

8. AGE: Years 76 Months 3 Days 27
If less than one day hr. min.9. Birthplace Georgetown Va
(Town, county, and state)

10. Usual Occupation Retired Boiler Helper

11. Industry or business

12. Name Simon Wagner

13. Birthplace Va

14. Maiden Name Ellen Royster

15. Birthplace Va

16 (a) Informant Ella M. Wagner

(b) Address 105 W. Hart Ave

17 (a) Burial (b) Date thereof Sept 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. d. 60

18 (a) Funeral director A. Donald Evans

(b) Address 1400 N. Charles St

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20, 1943, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17, 1943, to Sept 20, 1943, and that I last saw him alive on Sept 20, 1943.

Immediate cause of death Ch. pneumonia septica

Due to pneumonia septica

Due to

Other Conditions Arth. sclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul A. Lubato

Address 1213 Light St Date signed 9/22/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 21 1943

VS 124

Do not write on this certificate. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

440734
G 08364BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08364

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James Butters

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Cora -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-25-78-

8. AGE:

Years

Months

Days

If less than one day

68

-

24

hr. min.

9. Birthplace

Penn. -

10. Usual Occupation

Tool maker -

11. Industry or business

12. Name

Isaac Butters

13. Birthplace

New York -

14. Maiden Name

Adefande -

15. Birthplace

New York -

16 (a) Informant

Records -

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 21 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location - Charlston W. Va

18 (a) Funeral director

Geo S. Cook

(b) Address

1701-03 N. Patterson Park

19 (a) Date of death

Sept 21 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

W. Va

(b) County

(c) City or town

St. Albans -
(If outside city or town limits, write RURAL and give town)

(d) Street No.

2623 Furlong St
(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/19/43

1943 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1943 to Sept. 19 1943 and that I last saw him alive on 9/19/43 1943.

Immediate cause of death

PERITONITIS
overwhelming sepsis

Due to

Due to

Other Conditions

PNEUMONIA

Left lower lobe

(Include pregnancy within 6 months of death)

Date of operation

9/14/43

Major findings of operations

NONE -

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (Country) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John N. Kehne

M. D.

Address

John N. Kehne

Date signed 9-22-43

G08365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG08365
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 540 Prentiss St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN Wesley SINGLETON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced.

Widower

6 (b) Name of husband or wife

Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE:

Years

Months

Days

If less than one day

62

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(burial, cremation, or removal)

(b) Date thereof

9/24/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1943 at 10 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry
thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Burns, 1st and 2nd
degree, face + two-thirds body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 9-21-43 9:15 a.m.

(b) Where did injury occur? Restaurant, Balt.

(c) Did injury occur at home, on farm, industrial place, in public
place? home. While at work? No

(d) Means of injury Clothing ignited from cigarette

23. Signature H. Z. Wollenweber M.D.

Date signed 9-22-43

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1310

G 08366
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1108 E. Hoffman st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 E. Hoffman st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Bertha Karren

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. XXXX

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. May 6th 1870

8. AGE: Years Months Days If less than one day

73 4 14 hr. min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

Self

FATHER

12. Name

Adolph Karren

13. Birthplace

Raleigh N.C.

MOTHER

14. Maiden Name

Anna Zollihofer

15. Birthplace

Unknown

16 (a) Informant

Mary E. Grauer

(b) Address

1108 E. Hoffman st

17 (a)

Burial

(b) Date thereof 9/23/43

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul st

19 (a) Date of death

SEP 22 1943

(b) Signature

Thos. J. Williams

20. DATE OF DEATH

Sept 20th 1943 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1943 to Sept 20 1943, and that I last saw him alive on Sept 20 1943.

Immediate cause of death

Arteriosclerotic - Cardiac -
vascular renal disease

Due to

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. S. Blum
Address 1206 E. Preston st Date signed 9/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

440712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08367
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **45 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **721 McHenry St**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ernest Mullican

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

Alice

6 (c) If alive, give age **77** years

7. Birth date of deceased (mo., day, yr.) **4-16-66**

8. AGE: Years Months Days If less than one day

77 5 4 hr. min.

9. Birthplace **Fredrick Co, Md**

(Town, county, and state)

10. Usual Occupation

CARPENTER

11. Industry or business

12. Name **JAMES MULLICAN**

13. Birthplace **Md**

14. Maiden Name **VICTORIA LARK**

15. Birthplace **Md**

16 (a) Informant **RECORDS**

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **9/23/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium **St. Olivet**
Location **Fredrick, Md.**

18 (a) Funeral directors **William Cook Inc**

(b) Address **1217 St. Paul St**

19 (a) **Huntington Williams**

SEP 22 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 20 1943 2:00 AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 3 1943 to Sept 20 1943** and that I last saw him alive on **Sept 20 1943**

Immediate cause of death **Heart failure**

Due to

Due to

Other Conditions **Prostatic Hypertrophy**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **9/20/43**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Edw. J. Richardson Jr**

Address **Johns Hopkins Hosp** Date signed **9/20/43**

Duration

at

2:00

1:45

PHYSICIAN

Underline the cause to which death should be charged statistically.

8368

BALTIMORE CITY HEALTH DEPARTMENT

G 08368

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from June 8 1937, to Sept 20 1943.

and that I last saw her alive on Sept 13 1943.

Immediate cause of death

Ch. myocarditis

Arteriosclerosis of the aorta

Due to senility

Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 23 1943

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

3 (a) FULL NAME

Russell D. Phillips

3 (b) If veteran, name war

NO

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Madeline Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 - 1903

8. AGE: Years Months Days If less than one day

40

7

1

hr.

min.

9. Birthplace

Cook Co., Ill.

(Town, county, and state)

10. Usual Occupation

Foreman

11. Industry or business

A. T. Foreman

12. Name

Russell D. Phillips

13. Birthplace

Ill

14. Maiden Name

Tessie May

15. Birthplace

Ill

16 (a) Informant

Mrs Madeline Phillips

(b) Address

306 English Canal Ave

17 (a)

Burial

(b) Date thereof

9/23/43

(c) Cemetery

Green Haven

Location

Glenburnie Md.

18 (a) Funeral director

William Cook Inc

(b) Address

St Paul

19 (a)

Huntington Williams, Md

(b) Date rec'd by registrar

SEP 22 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

Street 306 English Canal Ave

(e) Citizen of foreign country? (If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1943 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1943 to 9-20 1943, and that I last saw him alive on 9-20 1943.

Immediate cause of death

Pneumonia

Right pneumothorax

Due to

Due to

Other Conditions Post operative

partial sleep

(Include pregnancy within 3 months of death)

Date of operation

9-15-43

Major findings of operations

Sanguineous

appendix

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Joseph B. Lautkaitis

Address

Franklin Square Hosp.

M. D.

Date signed

08370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08370
830 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 117 N. Eutaw

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 117 N. Eutaw

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles W. Belt

3 (b) If veteran, name was

W

3 (c) Social Security Account

No. TIME

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE:

62

Months

Days

If less than one day

hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

Walter S.FATHER
MOTHER12. Name Charles W. Belt13. Birthplace Towson, Md.14. Maiden Name Jimmie Bonano15. Birthplace Towson, Md.16 (a) Informant Charles J. Belt(b) Address 319 W. Madison St.17 (a) Burial (b) Date thereof 9/22/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Olaf

Location

Balto Md.18 (a) Funeral director William Cook Inc(b) SEP 22 1943 St. Paul St

19 (a) (Date rec'd by registrar)

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/181943 at 11:55 PM

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to met death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. Michally M.D.

Date signed

9/20/43

Medical Examiner.

(over)

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08371
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE FALLON CAREW

3 (b) If veteran, name war NO 3 (c) Social Security Account No. None

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Walton Carew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1861

8. AGE: Years 82 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Somerset County, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Edwin Ford

13. Birthplace Baltimore, Maryland

14. Maiden Name Virginia Scott

15. Birthplace Maryland

16 (a) Informant Mr. John Carew

(b) Address 1537 N. Appleton St.

17 (a) Burial (b) Date thereof 9/22/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1349 E. North Ave.

SEP 22 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1943 145 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to Sept. 1943 and that I last saw her alive on Sept. 3 1943

Immediate cause of death Cancer of Colon

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature With Currier M.D.

Address 2310 E. North Ave. Date signed 9/24/43

Duration 1 1/2 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

5372

440428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08372
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1919 Oakhill Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Joseph Garrell

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2-9-1870

8. AGE: Years

73

Months

7

Days

11

If less than one day

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Garrell

13. Birthplace

md.

14. Maiden Name

Salley Ward

15. Birthplace

md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Removal
(Burial, cremation, or removal)(b) Date thereof Sept 22
(month) (day) (year)

(c) Cemetery or crematory

Deer Creek Cem

Location

Belair Md

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2004-B. Orleans St

SEP 22 1943

(Date rec'd by registrar)

Hawthorne N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1943 at 12 P M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Sept 20 1943 and that I last saw him alive on Sept 20 1943

Immediate cause of death

Respiratory failure
Due to CA of neck & extension
into pharynx.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/1/43Major findings of operation: Excision
of CARC. of neck.
of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John H. Kehue MD.Address John H. Kehue MD. Date signed 9-21-43

Correct age is especially important. Every item of information should be carefully supplied. The age of the deceased is especially important. Physicians: please write the causes of death clearly and legibly.

373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 08373

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos. or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/20

1943, at 7:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1942 to 9/20 1942, and that I last saw her alive on 9/20 1942.

Immediate cause of death

Coronary Occlusion

Due to

Hypertensive Cardiovascular disease

Due to

Other Conditions

Cardiac Hypertrophy, Pulmonary Embolism

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

S. L. J. Smith

Address

Min. Hosp.

Date signed

9/24/42

Redwood + Jelliffe

SEP 22 1943

G 08374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08374

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Barney V. Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 18-1888

8. AGE:

Years

Months

Days

If less than one day

*55**-**34*

hr.

min.

9. Birthplace

Baltimore MD

(Town, county, and state)

10. Usual Occupation

Labourer

11. Industry or business

FATHER
MOTHER

12. Name

Richard Gross

13. Birthplace

MD

14. Maiden Name

Leela Gross

15. Birthplace

MD

16 (a) Informant

Barney V. Gross

(b) Address

1412 Presstman

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Sept 25-43

(c) Cemetery or crematory

Location

Huntingtown MD

18 (a) Funeral director

Sam M. Chase, Inc

(b) Address

638 N. E. Ave

19 (a)

SEP 23 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 22

1943, at

*9:30 P*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 18* 1943 to *Sept 21* 1943, and that I last saw *him* alive on *Sept 21* 1943.

Immediate cause of death

Coronary Occlusion

Due to

Thy pertussis

Due to

Other Conditions

*Paraneurymal**nephritis*
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *✓* While at work?

(Specify type of place)

(e) Means of injury

Signature

B. T. French

Address

2329 Arundel Ave

Date signed

9/23/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly.

G 08375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08375
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Green + Redwood St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 33Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3453 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Yetta
3 (b) If veteran, name was
3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 52 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

12. Name Nathan Klavansky

13. Birthplace Russia

14. Maiden Name Unkwn

15. Birthplace Russia

16 (a) Informant Samuel Topel

(b) Address 3453 Cottage Ave

17 (a) Burial (b) Date thereof Sept 22, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) SEP 22 1943 (b) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1943 at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20, 1943 to Sept 21, 1943 and that I last saw her alive on Sept. 21, 1943.

Immediate cause of death Hypertensive encephalopathy

Due to Hypertensive Cardiovascular disease

Due to

Other Conditions Consecutive heart failure, fibromyomatous uterus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. B. Hagan, M.D.

Address Univ. Hospital Date signed 9/21/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08376

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08376
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1613 Westwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1613 Westwood Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Eleanor S. Gwynn

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Charles Gwynn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1905

8. AGE: Years Months Days If less than one day

36 37 11 12 17 hr. min.9. Birthplace Charlottesville Va.
(Town, county, and state)10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Horace Solomon13. Birthplace Va.

MOTHER

14. Maiden Name Jannie ?15. Birthplace Va.16 (a) Informant Mr Charles Gwynn(b) Address 1613 Westwood Ave.17 (a) Burial (b) Date thereof 9-23-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery Charlottesville, Va.
Location18 (a) Funeral director Mr. Francis A. Hemmley(b) Address 5714 Biddle St.19 (a) SEP 22 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1943 at 9 A. M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the cause of death wereIMMEDIATE CAUSE OF DEATH Hypertensive
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Gnatow M.D.Date signed Sept. 20 1943
(over)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Greene Sts.*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2*

(e) Length of stay in Baltimore (yrs., mos., or days) *7*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County *Anne Arundel*

(c) City or town *North Linthicum*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *North Linthicum Rd*

(If rural, give location)

(e) Citizen of foreign country? *No*

(Yes or No)

If yes, name country

3 (a) FULL NAME

Max Schrader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife *Harriet Schrader*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

69 18 74

8. AGE: Years

69

Months

Days

If less than one day

hr.

min.

9. Birthplace

Maryland

(City, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

FATHER

12. Name

Max Schrader

13. Birthplace

Germany

MOTHER

14. Maiden Name

Margaret Schrader

15. Birthplace

Germany

16 (a) Informant

Wife

(b) Address

North Linthicum, Md.

17 (a)

Burial

(b) Date thereof *Sept 22 43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Fredrick St

18 (a) Funeral director

Robert L. Brooks

(b) Address

1338 Hollins St

19 (a)

(b)

(Date rec'd by registrar)

SEP 22 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-20-

19 *43* at *10¹⁰* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *9-18-43* to *9-20-43* and that I last saw him alive on *9-20-43*

Immediate cause of death

Respiratory Failure

Due to

Early Brain Abscess (Septic?)

Due to

Meningitis (Diffuse-pyogenic)

Other Conditions

Hypertension & Brain Possible Cerebral Vascular Accident

(Include pregnancy within 3 months of death)

Date of operation

9-19-43

Major findings of operation

Brain abscess (C) Cerebral edema (R)

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert L. Brooks

Address

University Hospital

Date signed *9/20/43*

Correct age is especially important. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

008378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

008378
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Tromer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. MARRIED.

6 (b) Name of husband or wife William S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/92

8. AGE: Years Months Days
51 yrs. 4 18
If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name James Fries

13. Birthplace Czech.

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Dolores Meran (daughter)

(b) Address 2513 Ashland Ave 40

17 (a) Burial (b) Date thereof 9/20/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location North Ave. Balto. Md.

18 (a) Funeral director Charles W. Schirumek

(b) Address 2601 E. Madison Street

SEP 22 1943

Stanton Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 19 43 at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 19 43 to 9-18 19 43, and that I last saw her alive on 9-18 19 43.

Immediate cause of death

Ruptured abdominal aortic aneurysm.

Due to

Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury

23. Signature Stanley B. Klyanowski

Address St. Joseph's Hospital Date signed 9-18-43

Duration

14 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

08379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49A

G 08379

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 22 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1943, to 9/19 1943, and that I last saw him alive on 9/19 1943.

Immediate cause of death

Carcinoma of ovaries & metastases

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operation: Carcinoma of ovaries & metastases

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed 9/19/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2212 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JOSEPH SOUKUP, SR.

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife: Barbara (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/69

8. AGE: Years 73 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Own Business & Tavern

11. Industry or business

12. Name Frank Soukup

13. Birthplace Czech

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Albert J. Soukup (Son)

(b) Address 4114 Moravia Avenue

17 (a) Burial (b) Date thereof 9/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Seimunek

(b) Address 2601 E. Madison Street

SEP 22 1943
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1943 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1943 to Sept 21 1943, and that I last saw him alive on Sept 20 1943.

Immediate cause of death

Hypertensive C.V. disease

Due to Apoplexy with

Hemiplegia &

Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles E. Seimunek

Address 801 N. Chesapeake Date signed 9/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

S 08381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHS 08381
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2452 E. Eager Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2452 E. Eager Street

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

MINNIE DECK

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/29/63

8. AGE: Years Months Days If less than one day

79 yrs

9

19

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Patrick Horist

13. Birthplace Ireland

14. Maiden Name Wilderman

15. Birthplace Germany

16 (a) Informant Marie Deck (daughter)

(b) Address 2452 E. Eager Street

17 (a) Burial (b) Date thereof 9/22/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or burying place Holy Redeemer

Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

SEP 22 1943
(Date of death) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-1943 M

21. I certify that death occurred on the date above stated; that I attended
deceased from [Signature] and that I last saw him alive [Signature]

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Correct age is especially important. Every item of information should be carefully supplied. The physicians: please write the causes of death clearly and legibly.

G 08382

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08382

Registered No.

124 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (specify number of days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 2187-01-3254

4 Sex Male

5 Color or race

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1872 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Year Months Days

66 7 21

If less than one day

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

SEP 22 1943

(b) Date registered

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2419 Annapolis

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1943 at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1943 to 9/19 1943, and that I last saw him alive on 9/19 1943.

Immediate cause of death

Cirrhosis of the Liver
Ascites

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Howard W. Stur

Address St Agnes Hospital Date signed 9/9/43

M. D.

08383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08383

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1114 Woodyear St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Arthur Gilbert

83554

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

black

6 (a) Single, married, widowed, or
divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1908

8. AGE:

Years

Months

Days

If less than one day

34

9

12

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

laborer

11. Industry or business

FATHER
MOTHER

12. Name

James Gilbert

13. Birthplace

Va.

14. Maiden Name

Mary Knox

15. Birthplace

Va.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

9/24/43

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1943, at 5:00AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 31 1943, to Sept. 21 1943,
and that I last saw him alive on Sept. 21 1943.

Immediate cause of death

Duration

Pulmonary tuberculosis

1 1/2 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Seigman

Address

BCH

Date signed

M.D.

9/24

The information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 22 1943

G 08384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08384

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

EMILY H. TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

JOHN H. TAYLOR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/13/1880

8. AGE:

Years

Months

Days

If less than one day

63

1

7

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

William H. Hoover

13. Birthplace

Md.

14. Maiden Name

Anna Katarina

15. Birthplace

Md.

16 (a) Informant

Mr. John H. Taylor

(b) Address

La Plata, Md.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

London Park & Co.

Location

Bkly Md.

18 (a) Funeral director

Wm. J. Tucker

19 (a)

(Date rec'd by registrar)

North & Penn. Ave.

SEP 22 1943

(Date rec'd by registrar)

H. W. Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20 1943, at 5 P.M.

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. W. Williams, Jr. M.D.

Date signed 9-21-43

08386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08386
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2789 The Alameda
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2789 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ESTELLE MARGUERITE STRAUSS

3 (b) If veteran, name war

--

3 (c) Social Security Account
No. none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife. George Leonard Strauss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1889

8. AGE: Years	Months	Days	If less than one day
54	7	22	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Lawrence Pistol

13. Birthplace Baltimore

14. Maiden Name Esther Hahn

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. George L. Strauss

(b) Address 2789 The Alameda

17 (a) Burial (b) Date thereof 9/24/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

22 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1943, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1943, to Sept 20 1943, and that I last saw him alive on Sept. 20 1943.

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertension and
chronic interstitial nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury W. Hoffmann M.D.

23. Signature J. East Road St. Date signed 9/24/43

Duration

11 hours

1 year +

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08387

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3722 Clarmount

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No 213-09-2194

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or other)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Cardiovascular

Hypertensive

Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Date

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

SEP 22 1943

Huntington, N.Y.

M. D.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08388

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Hospital Institution
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 1 day

3 (a) FULL NAME

Leonard John Morris Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 6 1943

8. AGE: Years 4 Months 6 Days 6 15 hr. min.

9. Birthplace

Ind

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name: Leonard Morris

13. Birthplace: Delaware

14. Maiden Name: Sallie Bythway

15. Birthplace: Pa.

16 (a) Informant: Leonard Morris

(b) Address: Blackbird Del.

17 (a) (Burial, cremation, or removal) (b) Date thereof: Sep 23 1943

(c) Cemetery or crematory: Union Church Amey
Location: near Maryland Del.

18 (a) Funeral director: J. J. Jester

(b) Address: Courthouse Del.

19 (a) SEP 23 1943

(b) H. J. Jester, Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State: Del (b) County: new castle

(c) City or town: Blackbird Del.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1943, 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1943 to Sept 21 1943, and that I last saw him alive on Sept 21 1943.

Immediate cause of death: Respiratory & Cardiac

Due to: Cachexia

Due to: Malnutrition

Other Conditions: (none)

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: H. J. Jester

Address: Union Memorial Hospital signed 9/21/43

Duration

1 mo.

1 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08389

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert J. Jones

3 (b) If veteran, name war

3 (c) Social Security Account

No. 220-05-9911

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

None

6 (b) Name of husband or wife

None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1905

8. AGE:

Years

Months

Days

If less than one day

38

hr. min.

9. Birthplace

Sunderland, Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Robert Jones

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Dorothy Johnson

15. Birthplace

Virginia

16 (a) Informant

Charles Jones

(b) Address

1929 Penna Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9-24-43

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

md

18 (a) Funeral director

George B. Nelson

(b) Address

1303 Preston St.

19 (a)

SEP 22 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 19, 1943, 6:45 M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Stab wounds

of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/19/43 at 6:30 P. M.

(b) Where did injury occur? 612 Sarah Ann St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Stabbed

23. Signature

Robert Lee Graham M.D.

Date signed

Sept. 20 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

08390

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08390

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2510 N. Charles St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---

(e) Length of stay in Baltimore (yrs., mos., or days) About 77 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County -----

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2510 N. Charles St.

(e) Citizen of foreign country? (If rural give location) ----- (Yes or No)

If yes, name country -----

3 (a) FULL NAME

Julia A. Hartigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced. Single

Female

White

6 (b) Name of husband or wife -----

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ----- 1866

8. AGE: Years Months Days If less than one day

About 77 --- --- -- hr. --- min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business -----

FATHER
MOTHER

12. Name Maurice Hartigan

13. Birthplace Ireland

14. Maiden Name Julia A. Aylward

15. Birthplace Ireland

16 (a) Informant Miss Alice Nugent

(b) Address 2510 N. Charles Street

17 (a) Burial (b) Date thereof 9/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director W. W. Meary and Son

(b) Address 805 N. Calvert St.

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 21 1943 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Apr 21 1943, and that I last saw him alive on Apr 20 1943

Immediate cause of death

Coronary Thrombosis
Myocardial Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Chastain

Address 1200 N. Calvert St. Date signed Apr 24 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08391

Registered No.

AB-83861

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 10 E. Madison St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 29-1865

8. AGE: Years Months Days

77

11

22

21

If less than one day

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George W. Simmons

13. Birthplace Mass.

MOTHER

14. Maiden Name Caroline Blake

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial

(b) Date thereof 9/22/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Landon Pk.

Location

Baltimore City

18 (a) Funeral director

C. Vernon Lamm

(b) Address

1611 Pk. H

19 (a) SEP 22 1943

H. J. Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/20

1943

at 12:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1943 to 9/20 1943 and that I last saw him alive on 9/20 1943.

Immediate cause of death

Atherosclerosis;
Coronary failure;
Due to A.S. C.V. disease
and cold. inf. pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. J. Sargman

Address

A.C.H.

Date signed

9/20

The age is especially important. Physicians: please write the causes of death clearly and legibly.

8392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 8392

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2229 St. Paul St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) - 12

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2229 St. Paul St.

(e) Citizen of foreign country? (If rural give location)

If yes, name country

(Yes or No)

3 (a) FULL NAME

R. Edward Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.)

1883

8. AGE:

Years

Months

Days

If less than one day

60

-- hr.

--- min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

CLERK

11. Industry or business

FATHER
MOTHER

12. Name

Richard E. Smith

13. Birthplace

Maryland

14. Maiden Name

Anne P. Rogers

15. Birthplace

Baltimore, Md.

16 (a) Informant Miss Margaret V. Smith

(b) Address 2229 St. Paul Street

17 (a) Burial

(b) Date thereof 9/22/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

Baltimore, Md.

18 (a) Funeral director

W. W. Mears

(b) Address

805 N. Calvert Street

SEP 22 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20th

1943 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19th 1943 to Sept 20 1943.

and that I last saw him alive on Sept 30

Immediate cause of death organic heart disease

Duration

15 yrs

Due to

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Leonard E Beach

Address 2229 St Paul St

Date signed 9/22/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08393

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08393
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

*MACK**GATER*

3 (b) If veteran, name war

3 (c) Social Security Account

No. *219-01-5615*

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1896

8. AGE: Years

47

Months

Days

If less than one day

hr.

min.

9. Birthplace *Birmingham, Alabama*
(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden Name

unknown

15. Birthplace

16 (a) Informant

Miss Rose Anderson

(b) Address

302 Exeter St.

17 (a)

Burial

(b) Date thereof

9/25/43
(month) (day) (year)

(c) Cemetery or crematory

St. Calvary

Location

Anne Arundel Co., Md.

18 (a) Funeral director

Adolphus Halstead

(b) Address

918 Druid Hill Ave.

(c) City

Baltimore, Md.

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d)

Street No.

*1013**Water St*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 17

19

*43*at *2:40 PM*

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Wound, lacerated neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

*9-17-43**1:45 P. M.*

(b) Where did injury occur?

1011 Water St

(c) Did injury occur at home, on farm, industrial place, in public

place?

home

While at work?

no

(d) Means of injury

struck by meat cleaver

23. Signature

W. H. Wallerstein M.D.

Medical Examiner

Date signed

9-17-43

G 08394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08394

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 409 N. Carey Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 18

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 409 N. Carey St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Shippy

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY SEP 22 1943

18 (a) Funeral director

(b) Address

19 SEP 22 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1943 at 2:00 P. M.21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Congenital
hydrocephalus, external

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed

August 19 1943
Medical Examiner

08395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08395

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hotel

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2101 Bayner Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Gine Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

PUBLIC CEMETERY SEP 22 1943

(a) Funeral director

Commissioner of Health

(b) Address

19

SEP 22 1943

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1943, at 2:05 PM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Prematurity
(6 months gestation)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Frutkin M.D.

Medical Examiner

Date signed Sept. 17, 1943

08396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08396

Registered No.

1. PLACE OF DEATH: Found Dead
 Baltimore City, Maryland
 (b) Street address 422 S Regester St.
 (c) Hospital or institution: Johns Hopkins Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
 (e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____
 (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

PUBLIC CEMETERY SEP 22 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 22 1943
(Date rec'd by Registrar)Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12, 1943, at 2:50 M

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

neglect after
birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature

Robert Lee Guterma M.D.
Medical Examiner.Date signed Sept. 17, 1943

Correct age is especially important. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08397

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1214 Broad St

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Fe

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 16, 1943

8. AGE: Years Months Days

If less than one day

17 hr. min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Otis Pierce

13. Birthplace North Carolina

14. Maiden Name Virginia Daniels

15. Birthplace North Carolina

16 (a) Informant Otis Pierce

(b) Address 1214 Broad St

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 22 1943

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 22 1943

(b) Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1214 Broad St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1943 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1943 to Sept 17 1943 and that I last saw her alive on Sept 16 1943

Immediate cause of death: Intracranial hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George S. Davis

Address University Hosp Date signed 9/17/43

308398

BALTIMORE CITY HEALTH DEPARTMENT

G 08398

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2320 Annapolis Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Westport
(c) City or town 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fielder B. Sears

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-09-4876

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Annie P. Sears

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24-1877

8. AGE: Years Months Days If less than one day
66 6 27 hr. min.

9. Birthplace Harwood Ind
(Town, county, and state)

10. Usual Occupation Carpenter Foreman

11. Industry or business

12. Name John Sears

13. Birthplace Maryland

14. Maiden Name Mary Phipps

15. Birthplace Maryland

16 (a) Informant Mrs. Annie P. Sears wife

(b) Address 2320 Annapolis Road

17 (a) Burial (b) Date thereof Sept 20 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery
Location Baltimore

18 (a) Funeral director Mamie Cook Syfer

(b) Address 1600 W. North Ave.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1943 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sept 21 1943 and that I last saw him alive on Sept 20 1943

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

Duration

6 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Belmont

Address 301 Anne St

Date signed 9 21 43

EP 23 1943

G 08399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08399

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Balt. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore Curtis Bay
(If outside city or town limits, write RURAL and give town)(d) Street No. 4503 W. Bay Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME William Barr

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

less than one day

928

hr.

min.

9. Birthplace

West Va.

Town, county, and state

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

EP 22 1943

(a) Date rec'd by registrar

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-1943 at 3:45 P.M.21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

ShockFractured Pelvis

Due to

Other Conditions

contusion of tissues &
muscles.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 9-21-43 at 3:15 P.M.(b) Where did injury occur? Fair Haven Church St. Curtis Bay(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? no(d) Means of injury Pedestrian, struck by auto-truck23. Signature Howard J. Walden M.D.Data signed 9-22-43

Medical Examiner.

G 08400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08400
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) "

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/43

8. AGE: Years Months Days If less than one day
hr. 20 min.9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edward Charles Jones Jr.

13. Birthplace Balto., Md.

14. Maiden Name Helen Mary Jacob

15. Birthplace Balto., Md.

16 (a) Informant Helen Mary Jacob

(b) Address 3216 W. Elden St.

17 (a) Burial (b) Date thereof 9-23-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto., Md.

18 (a) Funeral director Frank Brachdon

(b) Address 900 N. Bexter St.

19 (a) SEP 23 1943 (b) H. H. Williams, M.D.
(Date) (Signature) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3216 W. Elden St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/1943 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1943 to 9/22 1943, and that I last saw him alive on 9/22 1943.

Immediate cause of death Congenital Atelectasis

Due to Pneumonia (22 wks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Symonds Royce

Address Balto., Md. Date signed 9/22/43

Duration 20 min.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08401

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 N. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Henrietta E. Weber

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
female

5. Color or race
white

6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife John J. Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March , 1864

8. AGE: Years 79 Months 6 Days hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Jacob Fleckenstein

13. Birthplace Baltimore

14. Maiden Name ? Bradyhouse

15. Birthplace Baltimore

16 (a) Informant Anthony F. Weber

(b) Address 1708 Eutaw Place

17 (a) Burial (b) Date thereof 9/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery encumbered Holy Redeemer
Location Bel Air Road, Baltimore

18 (a) Funeral director John A. Mitchell & Sons, Inc.

(b) Address 1906 Eutaw Place

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 - 1943 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct 30 1943 to Sept 20 1943
and that I last saw her alive on Sept 20 1943.

Immediate cause of death

Cerebral Hemorrhage
Advanced atherosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis J. Jacob

Address 1700 Eutaw Place

Date signed

M. D.

9-24-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G 08402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08402
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1413 Light St.
(c) Hospital or institution: South Baltimore Female Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline CARMICHAEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/1942

8. AGE: Years 9 Months 7 Days If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

12. Name John Carmichael

13. Birthplace New Hampshire

14. Maiden Name Mildred Corniger

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mildred Carmichael

(b) Address 923 W. Lombard St.

17 (a) Burial (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory location 8800 1st Road

18 (a) Funeral director John J. Coran & Son

(b) Address 901 Hollins St.

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1943 at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1943 to Sept 22 1943 and that I last saw her alive on Sept 22 1943.

Immediate cause of death heart failure - infarction

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles B. McDonald M. D.

Address 1213 Light St Date signed 9-22-43

Duration

2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 23 1943

08403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08403
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to Sept 22 1943 and that I last saw him alive on Sept 22 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 yr

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 23 1943

G 08404

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08404

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2540 Boorman Ave.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 5(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

3 (a) FULL NAME

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Sol Loginsky

13. Birthplace

Russia

14. Maiden Name

Vera

15. Birthplace

Russia

16 (a) Informant

Wife

(b) Address

17 (a)

Burial

(b) Date thereof

9-23-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Koreopolis

Location

Chap. Rd. & Franklin Ave.

18 (a) Funeral director

Frank Lewis

(b) Address

1439 E. Balto. St.

19 (a)

(b)

By Registrar

Registrar

SEP 23 1943
William Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1022 E. Balto. St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-22-43at 11 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1943, to 9-20 1943, and that I last saw him alive on 9/20 1943.

Immediate cause of death

Carcinoma of lung (left)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

A. L. Hornstein

Address

733 Argyle St

Date signed

9/23/43

E3

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

8405

MJ-83857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d
G 08405
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry Brown

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Fannie Brown (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 2 1890

8. AGE: Years 53? Months ? Days ? If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Ben Brown

13. Birthplace ?

MOTHER 14. Maiden Name Beckie Wing

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sept 24 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location SAC Md

18 (a) Funeral director Sarah L Brown

(b) Address 1086 Montgomerystown

SEP 23 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1943 at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1943 to 9/18 1943, and that I last saw him alive on 9/18 1943.

Immediate cause of death Thrombosis on pulm. embolus

Due to A-S, C.V. Disease

2 marked cond. inflicting 7 mo.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seymour

Address B C H Date signed 9/20

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 08406
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1436 Pennsylvania Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME

*James OSCAR**GREEN*

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

Widower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 2, 1886

8. AGE:

Years

Months

Days

If less than one day

*57**2**19*

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

Stenographer

11. Industry or business

FATHER
MOTHER

12. Name

Delas Green

13. Birthplace

N.C.

14. Maiden Name

15. Birthplace

N.C.

16 (a) Informant

Ella Green

(b) Address

1436 Penna Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

9/24/43
(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

Md.

18 (a) Funeral director

Geo. H. Kelsan

(b) Address

1323 Presgman

19 (a)

SEP 23 1943
(Date rec'd by registrar)*Thurston H. Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 21 1943 at 12:20 PM*

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *9-20-43*

(b) Where did injury occur?

Getman's Car - Eastern

(c) Did injury occur at home, on farm, industrial place, in public place?

*at work*While at work? *yes*(d) Means of injury *piece of iron on Fulton wheel*

Signature

H. Z. Wallen

M.D.

Date signed *9-21-43*

08407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08407
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1628 N. Calver St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FANNY L. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced.

Mar

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/1900

8. AGE: Years Months Days
43 5 15
less than one day
hr. min.

9. Birthplace Va

(Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

12. Name Samuel Johnson

13. Birthplace Va

14. Maiden Name Bertha

15. Birthplace Va

16 (a) Informant Walter Miller

(b) Address 1628 N. Calver St.

17 (a) Burial, cremation, or removal

(b) Date thereof 9/24/43

(c) Cemetery or crematory

Location Mt. Airy

18 (a) Funeral director Geo. H. Nelson

(b) Address 1628 N. Calver St.

19 (a) SEP 23 1943

(b) Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1943

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. J. Wollenman M.D.

Date signed 9-24-43

08408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08408

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1939 Pennsylvania Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Jackson Powell

3 (b) If veteran, name war

W.W.

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-7-1898

8. AGE: Years Months Days If less than one day
45 3 12 hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER

12. Name Nathan Powell (D)

13. Birthplace Va.

MOTHER

14. Maiden Name Elizabeth Jackson

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Buried (b) Date thereof 9-24-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto National
Location and

18 (a) Funeral director George H. Wilson

(b) Address 1313 Prestonman St

19 (a)

(Date)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/43 19 at 10:5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1940 to 8-5 1943, and that I last saw him alive on 8-5 1942.

Immediate cause of death

Hemorrhage of R lung

Bronchial cancer L lung

Due to

Anemia of

Due to

Anemia of

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul H. Martin

Address R.C.H. Date signed 9-19-43

M. D.

correct age is especially important. Every item of information should be carefully supplied. The cause of death should be clearly and legibly written. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Every item of information should be carefully checked. Physicians: please write the causes of death clearly and legibly.

08409

JL- 83864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08409
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: **4940 Eastern Ave**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days): **6 days**
(e) Length of stay in Baltimore (yrs., mos., or days): **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Maryland** (b) County: **Baltimore**
(c) City or town: **Baltimore** (If outside city or town limits, write RURAL and give town)
(d) Street No.: **2531 N. Lanvale St.** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Charles H. German

3 (b) If veteran, name war

WW

3 (c) Social Security Account No. **11111**

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 27, 1868**

8. AGE: Years **75** Months **6** Days **25** If less than one day hr. min.

9. Birthplace **Ohio**

(Town, county, and state)

10. Usual Occupation **unemployed**

11. Industry or business

12. Name **Benjamin**

13. Birthplace **Md.**

14. Maiden Name **Mary Welch**

15. Birthplace **Md.**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **9/24/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Balto.**

Location **Balto Md**

18 (a) Funeral director **William Cook Inc**

19 **SEP 23 1943** **St. Paul**

(Date filed by registrar) (Signature of Registrar)

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 22, 1947**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 17, 1947** to **Sept 22, 1947**, and that I last saw him alive on **Sept 21, 1947**.

Immediate cause of death

fractionable acute coronary occlusion

Due to **arteriosclerosis CVD**

Due to

Other Conditions

Chronic Bronchitis, Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **W. J. Simpson**

Address **Balto City Md** Date signed **Sept 24, 1947**

Duration

minutes 99

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECORDS WILL BE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

480

G 08410

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1925 Riggs Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1925 Riggs Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Catherine Coburn

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed or divorced

Married

6 (b) Name of husband

David E. Coburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 7 - 1884

8. AGE: Years

59

Months

6

Days

14

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At home

FATHER

12. Name

James Nelson Wheeler

13. Birthplace

Va.

MOTHER

14. Maiden Name

Elnora Purcell

15. Birthplace

Va.

16 (a) Informant

David E. Coburn

(b) Address

1925 Riggs Ave

17 (a)

Burial

(b) Date thereof

9/24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

117 St. Paul St

19

SEP 23 1943

(Date rec'd by registrar)

Wm. H. Nelligan

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/21

1943. at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 9/21 1943, and that I last saw her alive on 9/20 1943

Immediate cause of death

Carcinoma of Cervix Uteri

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm. H. Nelligan

Address

401 N. Myson St.

Date signed

9/21/43

MacLaughlin

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

84111

WRITING PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08411
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Dennison St.

(c) Hospital or institution: Crawford Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

3 (a) FULL NAME

Clara R. Balke

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband ~~and~~ William Balke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1861

8. AGE: Years 82 Months 2 Days 0 hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

12. Name (Mother) Roberts

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Ida B. Sands

(b) Address 3801 W. Garrison Ave

17 (a) Burial (b) Date thereof 9/24/43

(c) Cemetery or crematory (d) Location

Donna Ridge Pikesville Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 S. Paul St

SEP 23 1943

Witnessing William M. B.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3801 W. Garrison Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1941 to Sept. 22 1943, and that I last saw him alive on Sept. 20 1943.

Immediate cause of death

11 - Intermittent - hemorrhage

Due to a) cerebral hemorrhage

Due to

Other Conditions - to

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul L. Chamberlain M.D.

Address 4108 Liberty St. Date signed 9/21/43

When FILLING IN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08412

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3021 Windsor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Leatitia Gelbach

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Widowed

6 (b) Name of husband or wife

George L. Gelbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 1st 1868

8. AGE: Years

75

Months

3

Days

20

If less than one day

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

Sold

12. Name

Charles Ellermeier

13. Birthplace

Germany

14. Maiden Name

Elizabeth F. Cooper

15. Birthplace

N. C.

16 (a) Informant

Elizabeth L. Gelbach

(b) Address

3021 Windsor Ave

17 (a)

Burial

(b) Date thereof

9/24/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery

Woodlawn

Location

MD.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

SEP 23 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1943 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1943 to Sept 21 1943, and that I last saw him alive on Sept 19 1943

Immediate cause of death

Carcinoma Stomach.

Due to

Due to

Other Conditions

Carcinoma Liver
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature John E. Shannon M.D.

Address

820 Mt. Airy Rd.

Date signed

9/24/43

G 08413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08413
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

3 (a) FULL NAME

Rita C. Hartman

3 (b) If veteran, name war

M

3 (c) Social Security Account

No.

None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband

Edward C. Hartman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1900

8. AGE: Years Months Days If less than one day

42

10

27

hr.

min.

9. Birthplace Wilkes-Barre Pa.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

Jacob Batz

13. Birthplace

Wilkes Barre Pa.

14. Maiden Name

Catherine Harker

15. Birthplace

Wilkes Barre Pa.

16 (a) Informant

Edward C. Hartman

(b) Address

2515 Maryland Ave

17 (a)

Burial

(b) Date thereof

9/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Baltimore Co. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19

SEP 23 1943

(Date rec'd by registrar)

(b) Registrar

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2515 Maryland Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1943, 10⁴⁶ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1943 to 9-21 1943, and that I last saw her alive on 9-21-1943.

Immediate cause of death

Cerebral hemorrhage

Due to Chronic Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Joseph B. Lauterbach

Address

Franklin Square

Date signed

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1366 Registered No. G 08414

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mo., or days) 10 days
(e) Length of stay in Baltimore (yrs., mo., or days) 1 1/2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel
(c) City or town USCG Tr.Sta., Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. USCG Training Station
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES FRANK LASLEY

3 (b) If veteran, name was

3 (c) Social Security Account
No. -

4. Sex
Male

5. Color or race
Col.

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1921

8. AGE: Years Months Days If less than one day
22 0 20 19 hr. min.

9. Birthplace Washington, Pa.

(Town, county, and state)

10. Usual Occupation St. M. 3/C (R) USCG

11. Industry or business USCG Tr.Sta., Curtis Bay, Md

12. Name James Lasley (Deceased)

13. Birthplace Staunton, Va.

14. Maiden Name Mary Striebling (Deceased)

15. Birthplace Staunton, Va.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Robert C. Walters

(b) Address 121 S. Stricker St.

SEP 23 1943

VB 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 20, 19 43, 10:20 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept. 11, 19 43, to Sept. 20, 19 43,
and that I last saw him alive on Sept. 20, 1943

Immediate cause of death Acute
pulmonary edema and toxic
hepatitis

Due to Sulfathiazole intoxica-
tion

Due to

Other Conditions Non-specific
urethritis, acute

(chronic pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 9/21/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

CG-47948

G 08415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08415
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address Calvert St.
 (c) Hospital or institution: Mercy Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
 (e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore
 (c) City or town Towson
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 59-1st St. (S.W.)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME Baby Boy Koch
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/43
 8. AGE: Years Months Days If less than one day
9 hr. 15 min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual Occupation Baby
 11. Industry or business

12. Name William Koch
 13. Birthplace Towson, Md.
 14. Maiden Name Grace Derrick
 15. Birthplace Maryland

16 (a) Informant Hospital Record
 (b) Address

17 (a) Burial (b) Date thereof 9/24/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Gowanus Presbyterian
 Location Gowanus, N.Y.

18 (a) Funeral director John Brown's Sons
 (b) Address Towson, Md.

SEP 23 1943 (Date signed by registrar)
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1943 to 9/23 1943, and that I last saw him alive on 9/23 1943.

Immediate cause of death Respiratory Failure

Due to Bleeding of the Newborn
(Hemorrhagic disease of newborn)
 Due to

Other Conditions premature

(Include pregnancy within 3 months of death)
 Date of operation

Major findings of operations
 of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. P. Moran

Address Mercy Hosp. Date signed 9/23/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08416
Registered No.

440057

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1029 N. Caroline
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Maggie Taylor

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female Black

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-058. AGE: Years Months Days If less than one day
38 7 - hr. min.9. Birthplace N.C.
(Town, county, and state)10. Usual Occupation None

11. Industry or business

12. Name John Southerland

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Records(b) Address JOHNS HOPKINS HOSPITAL17 (a) Burial (b) Date thereof Sept. 24/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory York - Calvary Cem.
Location G. A. County, Md.18 (a) Funeral director Mrs. R. A. Elliott & Dgt.(b) Address 1129 N. Caroline St.

SEP 23 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1943 at 7 A. M21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 23 1943 to Sept. 21 1943
and that I last saw him alive on Sept. 21 1943.

Immediate cause of death

Respiratory Failure

Due to Generalized infectionsEmpyema (L)Due to Subphrenic abscess (L)Following acute Peritonitis

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation Aug. 23-43 Aug. 11-43Major findings of operation Acute peritonitisSubphrenic abscess (L)

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles Thomas HatchAddress J. M. H.Date signed 9-21-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08417

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1707 Madison Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1707 Madison Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Rosa Carreon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

James Carreon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1986

8. AGE:

Years

Months

Days

If less than one day

57

hr.

min.

9. Birthplace

St. Mary's County Md.

(town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

FATHER
MOTHER

12. Name

Wm. H. Smith

13. Birthplace

St. Mary's County Md

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

James Carreon

(b) Address

1707 Mad. Ave.

17 (a)

Burial

(b) Date thereof

9-24-1948

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Peter's Cemetery

Location

Baltimore

18 (a) Funeral director

George F. A. Gibson

(b) Address

1735 Druid Hill Ave

19 SEP 28 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20 1948 at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948, to Sept 20 1948, and that I last saw him alive on Sept 20, 1948.

Immediate cause of death

Myocardial failure

Due to

Excessive catharsis

Duration

1 wk.

Due to

Probable int. hemorrhage

Other Conditions

from intestines

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George F. A. Gibson

M. D.

Address

1672 Druid Hill Ave

Date signed

9-24-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08418

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3654 Keswick Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

3 (a) FULL NAME

Otto H. Schratke

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-01-7990

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Annice V. Schratke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 4-1881

8. AGE:

Years

Months

Days

If less than one day

62

17

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

FATHER

12. Name

Christian Schratke

13. Birthplace

Germany

MOTHER

14. Maiden Name

Marie

15. Birthplace

Germany

16 (a) Informant

Miss Virginia Schratke

(b) Address

3654 Keswick Road

17 (a)

Burial

(b) Date thereof

Sept. 24-1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Lorraine

Location

Baltimore Co., Md.

18 (a) Funeral director

Burgee Funeral Home

(b) Address

3631 Fall Road

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3654 Keswick Road

(If give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 21-1943 at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1943 to Sept. 20 1943, and that I last saw him alive on Sept. 18 1943.

Immediate cause of death

Pulmonary Edema

Due to

Congestive heart failure

Due to

Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

At

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Lincoln T. F. Hardline

Address 904 W. 37th St.

Date signed Sept. 24

Duration

3 weeks

Due to

9 months

Due to

most years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

SEP 22 1943

Registrar

VS 154

G 08419

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08419

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Safeway & Tolens St.*

(c) Hospital or institution:

Hospital for Women of Maryland(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 years*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *3444 Keswick Road*
(If rural give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

MRS ALICE HARPER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *HOWARD J. HARPER*6 (c) If alive, give age *54* years7. Birth date of deceased (mo., day, yr.) *APRIL 10, 1881*

8. AGE: Years Months Days If less than one day

*62**5**12*

hr.

min.

9. Birthplace *LANCASTER COUNTY PENNSYLVANIA*
(Town, county, and state)10. Usual Occupation *HOUSEWIFE*

11. Industry or business

12. Name *HENRY LEHN*13. Birthplace *LANCASTER CO. PENNSYLVANIA*14. Maiden Name *MARY ANN BOYER*15. Birthplace *LANCASTER CO. PENNSYLVANIA*16 (a) Informant *Wife Howard J. Harper*(b) Address *3444 Keswick Road*17 (a) *Burial* (b) Date thereof *SEP 25 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Woodlawn*Location *Baltimore Co. Md.*18 (a) Funeral director *Durque Funeral Home*(b) Address *3631 Falls Road*19 (a) *SEP 23 1943* *Huntington Williams M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 22* 19 *48* at *11:10 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *September 1943* to *Sept 22 1943*, and that I last saw her alive on *Sept. 22 1943*.Immediate cause of death *Cardiac Failure*
Cardiac Asthma

Duration

Due to *HYPERTENSIVE, ATRIOVENTRICULAR*
HEART DISEASE

Due to

Other Conditions *Diabetes Mellitus*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Harland Edward Day*Address *Women's Hospital* Date signed *9/22/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08420

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Duneland & Rayner
(c) Hospital or institution: West Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) #1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Haughey (Charles E. Haughey, Sr.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elizabeth C. Haughey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 7, 1882

8. AGE: Years Months Days

61

2

18

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John B. Haughey

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Carrie McKewin

15. Birthplace Va.

16 (a) Informant Mrs. Elizabeth C. Haughey

(b) Address 2433 Maryland Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/25/43

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 23 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1943, at 5³⁰ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1943, to 9/21 1943, and that I last saw him alive on 9/21 1943.

Immediate cause of death

Pulmonary Embolus

Due to

Due to

Other Conditions

Carcinoma of Rectum

(Include pregnancy within 3 months of death)

Date of operation August 27, 1943

Major findings of operation: Carcinoma of Rectum

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?

(Specify type of place)

(e) Means of injury

23. Signature William M. Cheek

Address W B Galt Date signed 9/21/43

Registered No.

Address 1110 W. 14th Ave. Date signed 4-3-4

PLEASE PRINT, WITH UNFADING INK. Every item of information should be carefully supplied.
Physicians: please write the causes of death clearly and legibly.
 correct age is especially important

G 08422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08422
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Smith Bldg. Sec. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1433 Andre Street

(If rural give location)

Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Raesler

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-09-3284

MEDICAL CERTIFICATION

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Bertha Lewand6 (c) If alive, give age 40 years7. Birth date of deceased (mo., day, yr.) March 28 1898

8. AGE: Years Months Days If less than one day

45 5 24 hr. min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Laboy11. Industry or business Maryland Dry Dock

FATHER

12. Name Michael Raesler13. Birthplace Poland

MOTHER

14. Maiden Name Catherine Jawahowski15. Birthplace Poland16 (a) Informant Mrs Bertha Raesler(b) Address 1433 Andre St17 (a) Burial (b) Date thereof sep 25/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus CemLocation Baltimore City18 (a) Funeral director John W. Weber(b) Address 401 S. Chester St19 (a) SEP 23 1943(Date rec'd by registrar) Hamilton Williams20. DATE OF DEATH 9-21-1943 at 9:25 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

I find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of Brain

Due to

Other Conditions Defendant

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 9-21-43 at 9:20 P.M.(b) Where did injury occur? 1433 Andre Street(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no(d) Means of injury Self-inflicted gun shot of head23. Signature Horrold J. Muldoon M.D.Date signed 9-22-43 Medical Examiner.

G 08423

G 08423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Severn St., 3 Ward)Length of residence in city or town where death occurred yrs. mos. 113 How long in U. S. If of foreign birth? yrs. mos. ds.2. FULL NAME ANNIE HARRIS(a) Residence: No. 2210 Severn St., 3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. Color or Race <u>Color</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND or (or) WIFE of <u>John Harris</u>		
6. DATE OF BIRTH (month, day, year) <u>1867</u>		
7. AGE <u>76</u>	Years	Months Days
If LESS than 1 day, hrs. or min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (city or town) (State or country) <u>Waco, Tex.</u>		
13. NAME <u>Stephen Houston</u>		
14. BIRTHPLACE (city or town) (State or country) <u>Waco, Tex.</u>		
15. MAIDEN NAME <u>Sarah Carter</u>		
16. BIRTHPLACE (city or town) (State or country) <u>Waco, Tex.</u>		
17. INFORMANT <u>William H. Harris</u> (Address) <u>2210 Severn St.</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>W.T. Culbertson & Co. 9-24</u> 19 <u>43</u>		
19. UNDERTAKER <u>Wm. H. Williams</u> (Address) <u>2210 Severn St.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 21 194322. I HEREBY CERTIFY That I attended deceased from Sept 1 1943 to Sept 20 1943I last saw him alive on Sept 20 1943 Death is saidto have occurred on the date stated above, at 12 m.

The principal cause of death and related causes of importance were as follows:

Central HemorrhageSat and blood

Other contributory causes of importance:

Arterial Pressure

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 1943

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Richard L. Harris M. D.(Address) 2210 Severn St.

SEP 23 1943

Huntington Williams, M.D.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08425

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

704 Devonshire Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

(If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country?

If yes, name country

(If rural give location)

(Yes or No)

3 (a) FULL NAME

Frank H. Blockinger

3 (b) If veteran, name war

3 (c) Social Security Account

No. 14-05-3008

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Eva H. Blockinger

6 (c) If alive, give age

38 years

7. Birth date of deceased (mo., day, yr.)

Nov 3 - 1901

8. AGE:

Years

Months

Days

If less than one day

1

10

18

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Guard, Luf.

11. Industry or business

Copper Co. Bldg. Div.

FATHER
MOTHER

12. Name

William Blockinger

13. Birthplace

Baltimore, Md.

14. Maiden Name

Elizabeth Ebert

15. Birthplace

Baltimore, Md.

16 (a) Informant

Eva H. Blockinger

(b) Address

704 Devonshire Rd.

17 (a)

Funeral

(b) Date thereof

9/24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Mt. View

Location

3800 Redwood Road

18 (a) Funeral director

John F. Brown & Son

(b) Address

901 S. Hollins Street

19 (a) Registrar

William H. Williams, Jr.

20 (a) Date of death

Sept 21, 1943

21 (a) Date of death

Sept 21, 1943

22 (a) Date of death

Sept 21, 1943

23 (a) Date of death

Sept 21, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 21, 1943

at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

July 1943

to

Sept 20, 1943

and that I last saw him alive on

Sept 10, 1943

Immediate cause of death

Cardiac Failure

Due to

Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William H. Williams, Jr.

Address

301 W. 1st St.

Date signed

M. D.

9/20/43

SEP 28 1943

VS 156

G 08427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08427
Registered No.

T.N

83075

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Girl Collins (Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

C

6 (a) Single, married, widowed, or divorced. N.B

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

35

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Clarence Collins

13. Birthplace Unknown

14. Maiden Name Mary Brown

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave, Baltimore, Md.

17 (a) Cremated (b) Date thereof 9-22-43
(Burial, cremation, or removal) 9 AM (month) (day) (year)

(c) Cemetery or crematory B. C. H. Crematory

Location 4940 Eastern Ave.

18 (a) Funeral director B. C. H. Crematory

(b) Address 4940 Eastern Ave

SEP 23 1943

(Date filed by registrar)

(c) Registrar William M. D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1435 W. Franklin St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1943 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1943 to 9-7 1943, and that I last saw her alive on 9-7 1943.

Immediate cause of death

Hydrocephalus

Duration

35 days

Due to

Due to

Other Conditions Spinal Bifida

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Baltimore City Date signed 9-9-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 58

G 08428
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County
(c) City or town Baltimore
(d) Street No. 819 S. KENWOOD AVE.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas Daniels (or) Thomas J. Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No. 110 96

4. Sex M

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

White

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1934

8. AGE: Years 9 Months 7 Days 30 29 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

12. Name Andrew Daniels

13. Birthplace Baltio.

14. Maiden Name Agnes Skewers

15. Birthplace Baltio.

16 (a) Informant Andrew Daniels

(b) Address 819 S. KENWOOD AVE.

17 (a) Burial (b) Date thereof 9/2/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director M. W. E. Dippels Sons

(b) Address 400 N. E. 4th Ave. Ste. 100

SEP 23 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Cardiac Failure

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. W. Powers

Address Union Memorial Hosp. Date signed 9/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08429

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 911 Granby St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltim.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 911 Granby St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Antonio Pellegrini Marine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife Orazio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1859

8. AGE:

Years

83

Months

11

Days

17

If less than one day

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

retired

11. Industry or business

FATHER
MOTHER

12. Name

Pasquale Pellegrini

13. Birthplace

Italy

14. Maiden Name

Maria Cellucci

15. Birthplace

Italy

16 (a) Informant

Pasquale Marine

(b) Address

911 Granby St.

17 (a)

(Burial, cremation, or removal)

burial

(b) Date thereof

9/25/43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Bellevue Rd.

18 (a) Funeral director

Martin W.E. Doppelt Sons

(b) Address

Lombard & Ave Sts.19 (a) SEP 23 1943

(b)

William W. Williams

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1943 at 9:25 PM21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28, 187 to Sept. 21, 1943 and that I last saw him alive on Sept. 21, 1943.

Immediate cause of death

Congestive Heart FailureDuration
1 hourDue to ArteriosclerosisChronic MyocarditisDue to Chronic Nephritis

Unknown

Unknown

Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Philibert ArtigianiAddress 2942 E. Fayette St.Date signed 9/22/43

G 08430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08430

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Stratona Sts

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

3 (a) FULL NAME

KERMIT LLOYD

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1907

8. AGE:

Years

Months

Days

If less than one day

36

6

2

hr.

min.

9. Birthplace WEST VIRGINIA

(Town, county, and state)

10. Usual Occupation

TRUCK DRIVER

11. Industry or business

12. Name

Elder Lloyd

13. Birthplace

W. Virginia

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

(b) Address

Hospital Records

17 (a)

Burial

(b) Date thereof Sept 25 = 43.

(burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Spencer - W Va

18 (a) Funeral director

Wendell E. Humphrey

(b) Address

1501 N. Broadway

19 (a)

SEP 23 1943

Humphrey & Williams

Via - B+C

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write R/U/R/A, and give town)

(d) Street No.

605 - N. Calvert St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 22 1943, at 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 21 1943, to SEPT 22 1943, and that I last saw him alive on SEPT 22 1943

Immediate cause of death

Toxemia

Duration

Due to

Solar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Henry F. Zargara

Address

Mercy Hospital

Date signed 9/23/43

M. D.

NEVER WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08431

HAMBURY
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08431

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Regina Dukeland Ave*

(c) Hospital or institution:

West Balto Jail Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Granville A

3 (b) If veteran, name war

3 (c) Social Security Account

NO 12-03-9554

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed or divorced

Married

6 (b) Name of husband or wife

Elaine A. Hambury

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 12 - 1896*

8. AGE:

Years

Months

Days

If less than one day

46

11

11

hr.

min.

9. Birthplace

Balto. Md.

10. Usual Occupation

Maintenance Engineer

11. Industry or business

Mangel Herold Co

FATHER
MOTHER

12. Name

James Hambury

13. Birthplace

Md

14. Maiden Name

Eva Smith

15. Birthplace

Balto. Md.

16 (a) Informant

Elaine A. Hambury

(b) Address

4316 Berger Ave

17 (a)

Burial

(b) Date thereof

9/27/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Balto

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

SEP 24 1943

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4316 Berger*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 23 1943 - 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from *9-10 1943* to *9-23 1943* and that I last saw him alive on *9-23 1943*.

Immediate cause of death *Generalized abdominal carcinoma*
Due to unknown origin

Due to

Other Conditions

Ascites

(Include pregnancy within 3 months of death)

Date of operation

no

Major findings of operation:

of autopsy: *no*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

Signature

William Cook Inc

Address

4215 Federal St

Date signed

9/23/43

G 08432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08432

JL - 37201

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. No Home

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Henry Thien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 18, 1875

8. AGE:

Years

Months

Days

If less than one day

67

10

4

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Unemployed

FATHER
MOTHER

12. Name

Henry Thien

13. Birthplace

Germany

14. Maiden Name

Catherine ?

15. Birthplace

Germany

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial, cremation, or removal

(b) Date thereof 7/24/43

(c) Cemetery or crematory

Location Holy Redeemer

18 (a) Funeral director

(b) SEP 2 1943

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/22 1943 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/22 1943

and that I last saw him alive on 9/22 1943

Immediate cause of death

Carcinoma of rectum

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Seayman

Address

BCH

Date signed

7/23

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08433

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3108 Harford Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

3 (a) FULL NAME

Helen Marie Gerstmyer

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Louis Gerstmyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 - 1876

8. AGE: Years Months Days

67024

If less than one day

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

At home

11. Industry or business

Self

MOTHER FATHER

12. Name John S. Miller

13. Birthplace

Germany14. Maiden Name Catherine (Unknown)

15. Birthplace

Germany16 (a) Informant Wm A. Gerstmyer(b) Address 3108 Harford Rd17 (a) Burial(b) Date thereof 9/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Druid RidgeLocation Pikesville Md18 (a) Funeral director William Cook, Inc(b) Address 1217 St. Paul St19 (a) SEP 24 1943

VB 184

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Beth

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3108 Harford Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22nd 1943 2:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1943 to Sept 22 1943 and that I last saw him alive on Sept 22 1943.

Immediate cause of death

Cerebral HemorrhageDue to arteriosclerosis - 14 yearsDue to arteriosclerosis - 15 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature Louis F. KrummAddress 722 N. Leonard StDate signed Sept 23/43

Duration

Sept 21/435 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08434
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 600 E. 37th St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Gerke

3 (b) If veteran, name war

N

3 (c) Social Security Account

No. 1115

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Lena Gerke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27 - 18738. AGE: Years Months Days If less than one day
69 9 25 hr. min.9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Retired11. Industry or business Baker12. Name Gerke13. Birthplace Germany

14. Maiden Name

15. Birthplace

16 (a) Informant Elsie Al Esfert(b) Address 600 E. 37th St17 (a) Burial (b) Date thereof 9/25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Oak LawnLocation Eastern Ave. Extended18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul St.19 (a) SEP 25 1943 William Cook Registrar

(Date and signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1943 at 11 M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at 11 M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert C. Graham M.D.Date signed Sept. 29, 1943

Medical Examiner.

Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Petronilla Greil
3 (b) If veteran, name war 3 (c) Social Security Account No.
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Frank Greil (deceased) 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 21-1860
8. AGE: Years 83 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name John Probst 13. Birthplace Germany
MOTHER 14. Maiden Name Thersa 15. Birthplace Germany

16 (a) Informant Gertrude Greil (b) Address 2601 E. Oliver St.
17 (a) Burial (b) Date thereof 9-25-43 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Location

18 (a) Funeral director Leonard J. [unclear] (b) Address 5805 Madison Ave

19 (a) SEP 24 1943 (b) [unclear]

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept. 22, 1943, 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15, 1943, to Sept 22, 1943, and that I last saw her alive on Sept 22, 1943.
Immediate cause of death Myocarditis (chronic) Duration 1 yr.
Due to Arteriosclerosis 10 years
Due to Old Age
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Julius T. Gannon M. D.
Address 3812 Greenmount Ave Date signed 9/22/43

G 08436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08436

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 1630 E 78 St
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1630 E 78 St
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

Emma L. Laucht

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

G. William Laucht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 25 1871

8. AGE:

Years

Months

Days

If less than one day

71

8

27

26

hr.

min.

9. Birthplace

Baltimore City, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

G. William Laucht

(b) Address

1630 E 78 St

17 (a) Burial (b) Date thereof

Burial 9-24-43

(c) Cemetery or crematory

Barkwood

Location

Barkville

18 (a) Funeral director

Leonard G. Ruck

(b) Address

5305 1st St Rd

19 (a) SEP 24 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 21 1943 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943 to Sept 21 1943, and that I last saw her alive on Sept 21 1943.

Immediate cause of death

Acute Dehydration Throat

Due to
 Sclerous Sclerous
 Nephroses

Due to

Other Conditions Acute Sclerous

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
 (e) Means of injury

23. Signature

J. F. A. Stearns

Address 2878 Harford Rd

Date signed 9.22.43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48B

G 08437

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1928 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MYRTLE A. SELBY

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife George F. Selby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1905

8. AGE: Years

38

Months

8

Days

18

If less than one day

hr.

min.

9. Birthplace Lancaster, Va.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name James H. Webb

13. Birthplace Va.

14. Maiden Name Chloe Pittman

15. Birthplace Va.

16 (a) Informant Mr. George F. Selby

(b) Address 1928 W. Lanvale St.

17 (a) Burial (b) Date thereof 9/24/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b) Registrar

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1943 at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1943 to Sept. 21 1943, and that I last saw him alive on Sept. 21 1943.

Immediate cause of death

Cancer of the
Colon & Rectum.

Due to

Due to

Cancer of the
Colon & Rectum.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 812 N. Fulton St. Date signed 9/23/43

Duration

2 yrs
1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

Registered No. _____

Registered No. _____

Address 61/15, 1st floor, 1st street, 1st block, 1st area, 1st city, 1st state, 1st country signed 9.12.12

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

08439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08439

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Ashburton St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1213 Ashburton St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

EMORY W. MARSHALL

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or

divorced. married

6 (b) Name of husband or wife Agnes J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1897

8. AGE: Years Months Days If less than one day

46

1

9

hr.

min.

9. Birthplace St. Michaels, Md.

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

12. Name George H. Marshall

13. Birthplace Talbot Co., Md.

14. Maiden Name Matilda Jones

15. Birthplace Talbot Co., Md.

16 (a) Informant Mrs. Agnes J. Marshall

(b) Address 1213 Ashburton St.

17 (a) Burial (b) Date thereof 9.25.43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE CEM.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 24 1943

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1943, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1942, to Sep 22 1943, and that I last saw him alive on Sep 22 1943

Immediate cause of death

Cardiac Pathology

Due to

Rheumatic Heart.

Due to

Atherosclerosis

Other Conditions

Intercostal Neoplasm

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Arthur E. Zipp

Address 3048 N. North St

Date signed 9/24/43

Baltimore 16 Md

THESE WRITINGS MUST BE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08440
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

16-3
4 mo.

3 (a) FULL NAME

Martha Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

B

6 (a) Single, married, widowed, or divorced.

J

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

4

hr.

min.

9. Birthplace

Baltimore Md.

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

William Robinson

13. Birthplace

Va.

14. Maiden Name

Agnes Robinson

15. Birthplace

Md.

16 (a) Informant

William Robinson

(b) Address

1025 Vincent St

17 (a)

Burial

(b) Date thereof

9/25/42

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion

Location

Langdon, Md.

18 (a) Funeral director

Geo. H. Alayand

(b) Address

927 N. Mount St.

19 (a)

(b)

SEP 24 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1025 Vincent St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/23

1943, at 3:15 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from 9/23 1943 to 9/23 1943 and that I last saw her alive on 9/23 1943.

Immediate cause of death

Aspirin - severe

Due to

Dehydration

Due to

Insanitation

Other Conditions

(none)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. J. Coder

Address

Univ. Hosp.

Date signed

9/23/43

WRITING FAINTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 82463 08441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08441
Registered No.

121a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(d) Street No. 605 W. Mulberry St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ellen Mills

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex F 5. Color or race C 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife ? 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 36 ? Months ? Days ? If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Fred Johnson

13. Birthplace N. C.

14. Maiden Name Henrietta Blunt

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Shipped (b) Date thereof 9-24-43
(c) Cemetery or crematory Washington N. C.
Location Beaufort Co. N. C.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave.

19 (a) Registrar

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1943 at 9:00 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1943 to 9/20 1943 and that I last saw her alive on 9/20 1943

Immediate cause of death Cardiac failure

Due to Hypertensive C.V. renal disease & cong.

Due to decompensation 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. L. Sengman

Address B C H

Date signed 9/23

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08442

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08442
Registered No.

125 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 614 St. Hoffman St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 614 St. Hoffman St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Bertha Marie Sewell

3 (b) If veteran, name war

3 (c) Social Security Account

No.

None

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed or divorced

Married

6 (b) Name of husband or wife

George St.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 5, 1909

8. AGE:

Years

Months

Days

If less than one day

33

34

11

15

hr.

min.

9. Birthplace

Portsmouth, Va.

(City, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Richard Esipin

13. Birthplace

North Carolina

14. Maiden Name

Olivia Knight

15. Birthplace

Portsmouth, Va.

16 (a) Informant

George St. Sewell

(b) Address

614 St. Hoffman St.

17 (a)

Burial

(b) Date thereof

Sept. 24, 1943

(c) Cemetery or crematory

Location

Portsmouth, Va.

18 (c) Funeral director

Mrs. George St. Hoffman

(b) Address

14 E. Howard St. Ave

19 (a)

SEP 24 1943

(b) Date received by registrar

Huntington, N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20

1943

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 6 1943 to Sept 19 43

and that I last saw him alive on Sept 20 43

Immediate cause of death

Hepatic Abscess

Duration

3 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William F. Lutz

Address

5154 Gough

Date signed

9/23/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08443
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2345 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-22

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2345 Edmondson Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edward E. Roeske

3 (b) If veteran, name war

no.

3 (c) Social Security Account

No. 216-01-6932

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Elizabeth Roeske

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1877

8. AGE: Years 66 Months 6 Days 29 If less than one day

hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Buyer

11. Industry or business Butler Bros.

12. Name John F. Roeske

13. Birthplace Germany

14. Maiden Name Catherine Neefling

15. Birthplace Germany

16 (a) Informant Elizabeth Roeske

(b) Address 2345 Edmondson Ave

17 (a) Burial (b) Date thereof Sept 30, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral Director Mrs. M. J. Taylor & Son

(b) Address 801 W. Fayette St.

(b) I am Registrar

SEP 24 1943

VB 154

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1943 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1941 to Sept 22 1943, and that I last saw him alive on Sept 22 1943.

Immediate cause of death

Myocardial Insufficiency

Due to Atherosclerosis
chronic obstructive pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. W. Phillips

Address 2224 W. North Ave

Date signed Sept 23/43

Duration

6 mos.

2 yrs. 9 mos.

2 yrs. 9 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08444

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08444

Registered No.

937

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address South Baltimore Ave

(c) Hospital or institution:

1413 Light St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14.25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 2507 Brohawn Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Edward L. MERTZ

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Widower

6 (b) Name of husband or wife

Ruth Mertz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 10, 1879

8. AGE:

Years

Months

Days

If less than one day

64

3

12

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Groceryman

12. Name

John Mertz

13. Birthplace

Baltimore Md

14. Maiden Name

Amelia Pfetzer

15. Birthplace

Baltimore Md

16 (a) Informant

Edward J. Mertz

(b) Address

2507 Brohawn Ave.

17 (a)

Burial

(b) Date thereof

Sept 24, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

City

18 (a) Funeral director

Mrs. John W. Tengel & Son

(b) Address

801 W. Fayette St.

19 SEP 24 1943

(b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22, 1943, at 2:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21, 1943 to Sept 22, 1943, and that I last saw him alive on Sept 22, 1943.

Immediate cause of death

Atherosclerotic heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul H. Lubato

Address 1213 Light St. Date signed 9/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITERS PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08446

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 706 Lator Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Lator Ave
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1943 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1932 to Sept 22 1943, and that I last saw him alive on Sept 22 1943.

Immediate cause of death

Rupture of aneurysm of abdominal aorta

Due to Generalized arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy abdominal aortic aneurysm ruptured retroperitoneally

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 6210 York Road

Date signed Sept 24 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08447

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
1908 Orleans St

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2908 Orleans St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Elizabeth Suitor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ernest Suitor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1879

8. AGE: Years Months Days If less than one day

64

20

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William R Flake

Ga

13. Birthplace

MOTHER

14. Maiden Name Kizzer Mc Ilven

15. Birthplace

Ga

16 (a) Informant Mrs Margaret R Helney

(b) Address Memphis Tenn

17 (a) Burial (Interment, cremation, or removal)

(b) Date thereof Sept 27/43

(c) Cemetery or crematory

Woodlawn Cem

Location

Baltimore Co Md

Ullrich Funeral Home

18 (a) Funeral director 2008 Orleans St

(b) Address

19 (a) SEP 24 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

Sept 25/43

1.50

20. DATE OF DEATH 1943 at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Sept. 25, 1943.

Immediate cause of death

Cerebral Embolism

Duration 8 days

Due to Cardiac Enlargement

10 yrs.

Due to Hypertensive Cardiovascular Disease

?

Other Conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 713 Linden St Date signed Sept. 23, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08448

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

Baltimore

(c) City or town

Baltimore (Dundalk)

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Rose Phelps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Benjamin Phelps

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 28 1869

8. AGE:

Years

Months

Days

If less than one day

75 74

108

24

hr.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

12. Name

Josephus Lones

13. Birthplace

md

14. Maiden Name

Don't Know

15. Birthplace

16 (a) Informant

Mrs. Buster Seng

(b) Address

602 Tolna

17 (a)

(Burial, cremation, or removal)

Burial

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

Balto Co. md

18 (a) Funeral director

William Family Home

(b) Address

2008 Calcasieu

19 (a)

(Date registered)

SEP 24 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-22

1943

at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1943 to 9-22 1943

and that I last saw him alive on 9-22 1943

Immediate cause of death

Myocardial failure & dilatation of stomach
Due to carcinoma of gall bladder

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

9-18-43

Major findings of operations

Carcinoma of gall bladder & dilatation of stomach

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William

Address

Univ. Hospital

Date signed

SEP 24 1943

G 08449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08449
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 819 N. Bruce St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)(d) Street No. 819 N. Bruce St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Alice Colvin

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Divorced

6 (b) Name of husband or wife John Colvin

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1928

8. AGE: Years 65 Months 7 Days 9
hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

Domestic

FATHER
MOTHER

12. Name

Samuel Head

13. Birthplace

Md

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Robert Colvin

(b) Address

815 Bruce St

17 (a) Burial (b) Date thereof 9/25/43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

Md

18 (a) Funeral director

Mrs. H. Nelson

(b) Address

1303 Presnam St

19 (a) (b)
(Date rec'd by registrar)

Registrar

SEP 24 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1943 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from July 15 1943 to Sept 21 1943,
and that I last saw her alive on Sept 21 1943.

Immediate cause of death

Carcinoma of Liver

Due to Pulmonary metastases

Due to Pulmonary Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. William Fry

Address 1928 Pa Ave Date signed 9/23/43

Duration

2 months

3 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

Important: Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G 08450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08450

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Montgomery, Trans. Co.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

(Howard Percival Shook)

HOWARD PERCIVAL SHOOK

3 (b) If veteran, name war

Spanish-American

3 (c) Social Security Account

No. 212-01-5852

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Fannie Frances

Stevenaon Shook 6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) Oct. 29, 1878

8. AGE: Years Months Days If less than one day
64 1 10 7 22 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Traffic Agent

11. Industry or business Mundy Motor Truck Co.

12. Name Richard O. Shook

13. Birthplace Baltimore, Maryland

14. Maiden Name Margaret Day

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Fannie Shook

(b) Address 2793 1/2 Tivoli Ave.

17 (a) Burial (b) Date thereof 9/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 (a) (b) Registrar

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. 2796 1/2 Tivoli St.

(If rural give location)

(c) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-1943, at 9⁴⁰ AM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Howard J. Mulderis M.D.

Date signed 9-22-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08451

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Calvert & Haratoga*
(c) Hospital or institution: *Mary Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *12*
(e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
(c) City or town *Balt.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2300 E. Fayette*
(If rural, give location)
(e) Citizen of foreign country? *MB* (Yes or No)
If yes, name country

3 (a) FULL NAME

BARBARA CAROLYN NEUNSINGER

3 (b) If veteran, name war
NO

3 (c) Social Security Account
No. *NONE*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife *Charles Neunsinger*

6 (c) If alive, give age *53* years

7. Birth date of deceased (mo., day, yr. *Sept. 1, 1888*

8. AGE: Years

Months

Days

If less than one day

55

--

21

hr.

min.

9. Birthplace *Balt. Md.*
(Town, county, and state)

10. Usual Occupation *HW*

11. Industry or business

12. Name *Casper Getz*

13. Birthplace *Balt.*

14. Maiden Name *Elizabeth Bain*

15. Birthplace *Balt.*

16 (a) Informant *Charles Neunsinger*

(b) Address *2300 E. Fayette St.*

17 (a) *Burial*

(b) Date thereof *9/25/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Oaklawn Cemetery*

Location *Baltimore County, Md.*

18 (a) Funeral director *Henry Sander & Sons*

(b) Address *North Ave. & Broadway*

19 (a)

(Date of registration)

SEP 24 1943

for William M. R.

Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 22 1943*, at *12:40 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 10 1943* to *Sept 22 1943*, and that I last saw him alive on *Sept 22 1943*.

Immediate cause of death

Cardio-Respir. Failure

Due to *Embolus*!

Due to *Post-operative - Gall Bladder*

Other Conditions

(Include pregnancy within months of death)

Date of operation *Sept. 11, 1943*

Major findings of operation *acute cholecystitis*

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Margaret L. Adelscheltz M.D.*

Address *Mary Hosp*

Date signed *9/24/43*

G 08452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08452

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital 26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No 105 Highland Ave
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

(Louis Klein) PHILIP LOUIS KLEIN

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Florence Klein

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 15, 1872

8. AGE: Years Months Days If less than one day
71 4 3 hr. min.9. Birthplace Ellicott City, Maryland
(Town, county, and state)

10. Usual Occupation Railroad

11. Industry or business Retired

12. Name Chris Klein

13. Birthplace Germany

14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant: Reta Louis

(b) Address 2304 Windsor Road

17 (a) Burial (b) Date thereof 9/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

SEP 24 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1943 11:05 PM

21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McEllyria

Date signed 9/21/43

Medical Examiner

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08453

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 103 S. Linwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 103 S. Linwood Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNA MARGARET ACKERMANN

3 (b) If veteran, name war
No

3 (c) Social Security Account
No. None

4. Sex
F

5. Color or race
W

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Charles G. J.
Ackermann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1833

8. AGE: Years Months Days If less than one day
80 5 24 23 hr. min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Louis Egner

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Louis Wyble

(b) Address 103 S. Linwood Ave.

17 (a) Burial (b) Date thereof 9/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc

(b) Address North Ave. & Broadway

SEP 24 1943
(Day, month, and year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1943, at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 1, 1942 to Sept 22, 1943.
and that I last saw him alive on Sept 22, 1943.

Immediate cause of death

Coronary of Stomach

Duration
8/1/42

Due to

Due to

Arterio sclerosis

9/21/43

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of transport

23. Signature William J. Roanek

Address 801 S. Remond Date signed 9/24/43

PHYSICIAN
Underline the
cause to which
death should be
charged statisti-
cally.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08454 MJ-20032

G 08454
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs., 8 mos., 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 927 Peach Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife James (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1876

8. AGE: Years

66

Months

11

Days

0

If less than one day

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Henry Seward

13. Birthplace Maryland

14. Maiden Name Kate Thomas

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (b) Date thereof 9 29 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

(Date rec'd by registrar)

Registrar

SEP 24 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/43 19 at 11:55 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/21 1943 and that I last saw her alive on 9/21 1943

Immediate cause of death

Prob. cerebral accident

Duration 2-3 hrs

Due to Hypertensive C.V. disease

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman

Address B C H

Date signed 9/21

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08455
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 N. CALHOUN ST.

(c) Hospital or institution:

Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

3 (a) FULL NAME

Baby Boy MARTIN.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1943.

8. AGE: Years

3 day

Months

Days

If less than one day

hr. min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Carroll Paul Martin

13. Birthplace Upperco, Md.

14. Maiden Name Katherine Klobner

15. Birthplace Owings Mills, Md.

16 (a) Informant C. Paul Martin

(b) Address Reisterstown, Md.

17 (a) Burial (b) Date thereof Sept 24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Balto Co Md

18 (a) Funeral director Edw. C. Tipton

(b) Address

19 (a) SEP 24 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 112 Hanover Rd.

Reisterstown, Md. (see location)

(e) If foreign born, how long in U. S. A?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1943, to Sept 23 1943, and that I last saw him alive on 9-22 1943.

Immediate cause of death

Broncho Pneumonia

Duration

18 hrs.

Due to Aspiration of vomitus

18 hrs.

Due to

Other Conditions Prematurity

3 da.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature S. D. Caplan

M. D.

Address Reisterstown, Md. Date signed 9-23-43

G 08456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08456
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **411 Angelsea St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **411 S. Angelsea St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George H. Ving

3 (b) If veteran, name war

3 (c) Social Security Account

No. **219-18-1455**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife **Jennie I. Ving**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Dec. 20, 1889**

8. AGE: Years

53

Months

9

Days

2

If less than one day

hr.

min.

9. Birthplace **Baltimore Md.**

(Town, county, and state)

10. Usual Occupation **Machinist, Beth Fairfield**

11. Industry or business

12. Name **Charles Ving**13. Birthplace **Unknown**14. Maiden Name **Margaret Elgert**15. Birthplace **Md.**16 (a) Informant **Mrs. Jennie I. Ving**(b) Address **411 S. Angelsea St.**17 (a) **Burial** (b) Date thereof **Sept. 24/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Oak Lawn Cem.**Location **Balto. Md.**18 (a) Funeral director **Philip Morgan**(b) Address **2024 Orleans St.**19 (a) (b)
(Date and by registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 22/43** 19 **at 5 A. M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Jan. 19, 1941** to **Sept. 22, 1943**, and that I last saw him alive on **Sept. 20, 1943**.

Immediate cause of death

Hodgkin's Disease

Duration

3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury **Philbrick Artisan**23. Signature **Philbrick Artisan**
Address **2942 E. Fayette St.** Date signed **9/24/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08457
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Yulkens & Caton Aves.*

(c) Hospital or institution:

St. Agnes Hospital 13-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *3816 Elm Ave. - Hampden*
(If give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Boy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 17, 1943*

8. AGE: Years Months Days

6 hr. min.
If less than one day

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Robert E. Taylor, Jr.

13. Birthplace

md.

14. Maiden Name

Dorothy Buck

15. Birthplace

Ppa.

16 (a) Informant *Robert E. Taylor, Jr.*

(b) Address *3816 Elm Ave*

17 (a) *Burial* (b) Date thereof *Sept 24/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Moulton Park*
Location *Taylor Ave*

18 (a) Funeral director *E. J. Brown & Sonoran*

(b) Address *3615-17 Chestnut Ave*

19 *SEP 24 1943* (b) *Huntington Williams, M.D.*
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 23, 1943, at 11:00 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9-17 1943* to *9-23 1943* and that I last saw *last* alive on *9-23 1943*.

Immediate cause of death

Central Pneumonia

Due to *Cerebrovascular stroke*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *W. J. Bryan* *7-2*
St Agnes Hosp Date signed *9/24/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08458

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 W. Cold Spring Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 W. Cold Spring Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Ada Frances Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Joseph D. Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 26, 1856

8. AGE:

Years

Months

Days

If less than one day

861026

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name

Milton Day

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Sarah Smith

15. Birthplace

Maryland

16 (a) Informant

Era J. Barnes

(b) Address

1427 W 36th St.

17 (a)

Burial

(b) Date thereof

Sept 25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Spring Ridge

Location

Pikesville

18 (a) Funeral director

Chenoweth & Sonoran

(b) Address

3615-17 Chestnut Ave.

SEP 24 1943

(b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1943, at 11¹⁰ A.M.21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1943, to Sept 19, 1943and that I last saw him alive on Sept 21, 1943.

Immediate cause of death

Cerebral Stenosis &cardiac decompensationDue to arterio-sclerosis& hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John D. Williams

Address

846 W 36th St.

Date signed

9/22/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08459

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08459

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd. 1943. at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3rd. 43 to Sept. 22nd. 43.

and that I last saw h. or alive on Sept. 22nd. 43.

Immediate cause of death

Multiple Sclerosis

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

401 E. 25th. S.

Date signed 9/24/43.

SEP 24 1943

A31385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08460
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1030 N. Wolfe
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lelia Mariner

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-4-43

8. AGE: Years

Months

Days

If less than one day

318

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

William Mariner

13. Birthplace

14. Maiden Name

Helen Hightower

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) Burial(b) Date thereof Sept. 24/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Int. Calvary Cemetery

Location

A. A. County Md.

18 (a) Funeral director

Mrs. Robert A. Ellis & Sps.

(b) Address

1129 N. Caroline St.

19 (a)

(b) Hamington Williams, M.D.SEP 24 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1943 6 PM21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1943 to Sept. 22 1943, and that I last saw her alive on Sept. 22 1943Immediate cause of death Shock

Duration

9 hrsDue to 2 to 3 hours

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Johns Hopkins Hosp Date signed 9/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08461
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/23

1943 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1943 to 9/23 1943, and that I last saw him alive on 9/22 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed 9/23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08462
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address 1429 Mt Royal Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) * 14
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

3 (a) FULL NAME

Edward Addis Morrison

3 (b) If veteran, name war
NONE

3 (c) Social Security Account
No. 216-07-0711

4. Sex
MALE

5. Color or race
White

6 (a) Single, married, widowed, or divorced
MARRIED

6 (b) Name of husband or wife
AGNES L. MORRISON

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) JUNE 3-1884

8. AGE: Years 59 Months 3 Days 20
If less than one day hr. min.

9. Birthplace SMITHFIELD, VA
(Town, county, and state)

10. Usual Occupation XRAY MAN

11. Industry or business KELLY HOSPITAL

12. Name EDWARD ADDIS MORRISON

13. Birthplace VIRGINIA

14. Maiden Name ETTA WATKINS

15. Birthplace VIRGINIA

16 (a) Informant MRS AGNES L. MORRISON

(b) Address 1429 Mt ROYAL AVE

17 (a) SHIPPED (b) Date thereof 9/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ST. MARY'S
Location CORTLAND N.Y.

18 (a) Funeral director Chas. J. Evans, Jr.

(b) Address 118 N. Mt. Royal Ave

19 (a) SEP 24 1943 (b) Washington, D.C.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1429 Mt ROYAL AVE
(If rural give location)

(e) Citizen of foreign country? * * * (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.23 1943 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9.23. 1942 to 9.23 1943, and that I last saw him alive on 9.23 1943.

Immediate cause of death
Coronary
Necrosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? at M

(d) Did injury occur about home, on farm, industrial place, in public place? (City or town) (County) (State)
While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Neil Jr.
Address 1418 Eutaw Pl

Date signed 9.24.43

Duration
& home

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08463

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1010 E. Biddle St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Pauline B Radcliffe

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Samuel W. Radcliffe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1861

8. AGE: Years

Months

Days

If less than one day

81

9

18

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

David Dobler

13. Birthplace

Ind.

14. Maiden Name

Margaret Fox

15. Birthplace

Germany

16 (a) Informant

Mrs. Radcliffe

(b) Address

1010 E. Biddle St

17 (a) Burial

(b) Date thereof Sept 27, 1943

(Burial, cremation, or reinterment)

(month, day, year)

(c) Cemetery or crematory

London Park

Location

Baltimore

18 (a) Funeral director

Edith Wiedefeld

(b) Address

914 Greenmount Ave

19 (a)

William Williams

SEP 24 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1010 E. Biddle St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 1943, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10, 1943; to Sept 24, 1943; and that I last saw her alive on Sept 23, 1943.

Immediate cause of death

Coronary Thrombosis

Due to

arteriosclerotic Cardio-Vascular

Due to

renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James S. Blum M.D.

Address

1206 E. Preston St

Date signed

9/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08464

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley Street

(c) Hospital or institution:

Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Jensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

Elizabeth Truley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1863

8. AGE:

Years

Months

Days

If less than one day

80

hr.

min.

9. Birthplace New London, Conn.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name

John

13. Birthplace

?

MOTHER

14. Maiden Name

Elizabeth Truley

15. Birthplace

?

16 (a) Informant Little Sisters of the Poor

(b) Address 1201 Valley St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept 25, 1943

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore

18 (a) Funeral director

Rita Woodfield

(b) Address

914 Greenmount Ave

19 (a)

Witnessed by

William Williams, M.D.

MEDICAL CERTIFICATION

8:30 a.m.

20. DATE OF DEATH Sept. 23, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 - 1943, to Sept 23 - 1943, and that I last saw him alive on Sept 22 - 1943.

Immediate cause of death

Acute Dilatation of Heart

Duration

1 day

Due to

Chronic Myocarditis

8 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. Gill Hall

Address 16318 North Ave.

Date signed 9/24/43

G 08465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08465

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd. Sts.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (month) (days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Charles Wallace High

3 (b) If veteran, name war

NONE

3 (c) Social Security Account No. 216-07-2949

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. C. W. High (Eleanor H. High)

7. Birth date of deceased (mo., day, yr.) Jan 8th 1888 (1888)

8. AGE: Years 58 54 Months 8 Days 34

If less than one day

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Sattler Co.

12. Name Charles A. High

13. Birthplace Baltimore, Md.

14. Maiden Name Lilla Freeman

15. Birthplace Virginia

16 (a) Informant Mother - Mrs. Charles A. High

(b) Address 2506 N. Charles St. (A. 5849)

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Sept. 27, 1943

(c) Cemetery or crematory Loudon Park

Location

Baltimore, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN, INC.) 108 W. NORTH AVENUE

(c) Date rec'd by registrar SEP 24 1943

(d) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) ~~City~~ Baltimore

(c) or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2712 N. Howard St.

(e) Citizen of foreign country (If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24

1943. at 3²⁰ A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13th 1943. to Sept 24 1943. and that I last saw him alive on Sept 24 1943.

Immediate cause of death

Cardiac failure

Due to Staphylococcus Pneumonia + Septicemia

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place? (City or town) (County) (State)

(Specify type of place)

While at work?

(e) Means of injury

23. Signature John A. Trebilcock

Address Union Memorial Hospital

Date signed 9-27-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Age is especially important. Physicians: please write the causes of death clearly and legibly.

G-08460 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4607 Mammota Ave, 16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. of foreign birth? yrs. mos. da.

2. FULL NAME

Hannie (Fanny) Gertrude Halloran

(a) Residence: No. 9251 N. Fulton Ave St. Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. Color or Race White 5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced (or) WIFE of James H. Halloran

6. DATE OF BIRTH (month, day, year) Sept. 20, 1878

7. AGE Years 65 Months — Days 3 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Sales Lady Capital Cake Co

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Rossville, Pa.

13. NAME John F. M. (Clellan)

14. BIRTHPLACE (city or town) (State or country) Rossville, Pa.

15. MAIDEN NAME Emeline Benedict

16. BIRTHPLACE (city or town) (State or country) Rossville, Pa.

17. INFORMANT Family (Address)

18. BURIAL, CREMATION, OR REMOVAL Place York Pa. Date 9/25/1943

19. UNDERTAKER William E. Radon (Address) 1200 Sheldon Ave

SEP 24 1943

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 23, 1943

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1943 to Sept 23, 1943

I last saw her alive on Sept 23, 1943 Death is said to have occurred on the date stated above, at 11 P. M.

The principal cause of death and related causes of importance were as follows:

Incurable Carcinoma of the Breast Date of onset 3 mos

Other contributory causes of importance:

Carcinoma - Left breast 4 yrs

Name of operation (Germinal Breast 1943) Date of July 43

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Wm. E. Radon M. D.

(Address) 1200 Sheldon Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Beane 08467

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Church Home & Infirmary 11 Broadway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Miss Ida V. Beane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1859

8. AGE: Years Months Days If less than one day

84 6 1 hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Otto Beane

13. Birthplace Germany

14. Maiden Name Margaret Pipino

15. Birthplace Italy

16 (a) Informant Mrs. Ernest Schwartz

(b) Address 2017 Euterio Place

17 (a) Burial (b) Date thereof 9/25/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Balto., Md.

18 (a) Funeral director Wm. J. Fickner & Sons

(b) Address Balto., Md.

SEP 24 1943

VS 120

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1943, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1943, to Sept 23 1943, and that I last saw her alive on Sept 23 1943.

Immediate cause of death

Hypostatic pneumonia

Duration

2 days

Due to Septicemia result of femur, right

Due to

Other Conditions Arteriosclerotic heart disease & cardiac asthma

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following: 45

(a) Accident, suicide, or homicide Accident -

(b) Date of occurrence 9-18-43 at 2 P.M.

(c) Where did injury occur? Baltimore Md

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? None

(Specify type of place)

While at work? No

(e) Means of injury Fall in own room

23. Signature Isabella Harrison

M. D.

Address Church Home & Hospital Date signed 9-23-43

For St. L. Hollander, for Howard J. Mallon MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08468
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1113 Light St.

(c) Hospital or institution:

South Baltimore full Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 16 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County City Balt

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1215 Pilot Court (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Loyce MILLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 - 1914

8. AGE: Years 29 Months 15 Days 15 hr. min.

9. Birthplace Rock Blaine S.C.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name William W. Bunyan

13. Birthplace Monroe N.C.

14. Maiden Name Ada Goyns

15. Birthplace N.C.

16 (a) Informant Lee Mills

(b) Address 1215 Pilot Court

17 (a) Burial, cremation, or removal (b) Date thereof Sept 18/43 (month) (day) (year)

(c) Cemetery or crematory Monroe N.C.

Location

18 (a) Funeral director William Cook

(b) Address 1217 St Paul Street

19 (a) (b) Registrar

SEP 24 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1943 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1943 to Sept 24 1943, and that I last saw her alive on Sept 24 1943.

Immediate cause of death Rheumatic heart disease, inactive

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Theodore J. Goyns

Address So. Balt. Pan Hosp Date signed 9/24/43

Duration

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

200313

G 08469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 467

G 08469
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 W. BARRE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY A. WILLIAMS
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife CATHERINE S. WILLIAMS
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 1, 1869
8. AGE: Years 74 Months 4 Days 22 If less than one day hr. min.

9. Birthplace MD Calvert County, Md.
(Town, county, and state)

10. Usual Occupation Retired Clerk
11. Industry or business Sharp & Dohme

12. Name FATHER WILLIAMS
13. Birthplace MD Calvert County
14. Maiden Name NANCY BEVERLY
15. Birthplace MD Calvert County

16 (a) Informant RECORDS
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 25, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Adelle Lamoreaux
(b) Address 1005 W. Baltimore St.

19 SEP 24 1943
Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 19 43 at 105 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 19 43 to 9/23 19 43, and that I last saw him alive on 9/23 19 43.

Immediate cause of death
ACUTE CORONARY HT. DISEASE
Due to ARTERIO SCLEROSIS
Due to
Other Conditions CARC. of RECTUM.
(Include pregnancy within 3 months of death)
Date of operation 9/14/43
Major findings of operations: CARC. of RECTUM.
of autopsy.

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature W. Langman Jr.
Address John Hopkins Hosp signed 9/24/43

The information on this certificate is to be used for statistical purposes only. It is not to be used for legal purposes. Please write the causes of death clearly and legibly.

G 08170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08170
163H Registered No.

1. DATE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 Deering Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Deering Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aura
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-8608

4. Sex F. 5. Color or race W 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1909
8. AGE: Years 34 Months 2 Days 13 If less than one day
hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Inspector of Am. Station Ring Co
11. Industry or business

FATHER
12. Name James Sasser
13. Birthplace Md.
MOTHER
14. Maiden Name Margaret Warner
15. Birthplace Md.

16 (a) Informant Mrs. Louis C Hundertmark
(b) Address 1909 Deering St House PK

17 (a) Burial (b) Date thereof Sept 25 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Brooklyn Md

18 (a) Funeral director William M Marech
(b) Address 715 E. 14 St

R 24 1943
(Date rec'd by registrar) William M Marech

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept. 22 1943 at 6 50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were: Asphyxiation due to carbon monoxide

Due to
Other Conditions Mental dependency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 22 1943 5 P.M.
(b) Where did injury occur? 1909 Deering Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Turned on furnace gas stove
23. Signature Robert L. Graham M.D.
Medical Examiner
Date signed Sept. 22 1943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08471
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 24 1943

18 (a) Funeral director

(b) Address

19 SEP 24 1943

(b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1943 to 9/22 1943 and that I last saw him alive on 9/22 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M.D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08472

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Univ Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2627 E. Madison St.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Winfield Rupp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 24 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

Hamington Williams, M.D.
Registrar

SEP 24 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/18

1943 11 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 1943 to 9/18 1943.

and that I last saw him alive on 9/18 1943

Immediate cause of death

Pulmonary Embolism.

Due to Following amputation of leg due to Cancer.

Due to Diabetes.

Other Conditions

(Include pregnancy within 3 months at death)

Date of operation 9-3-43 + 9-15-43

Major findings of operation:

Cancer of leg.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. Williams, M.D.

Address

Univ. Hosp

Date signed

9/19/43

Age is especially important. Physicians: please write the causes of death clearly and legibly.

08473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08473

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mass. (b) County(c) City or town Boston

(If outside city or town limits, write RURAL and give town)

(d) Street No. 38 Concord St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1891

8. AGE:

Years

Months

Days

If less than one day

52

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

Sept 27-43

(c) Cemetery or crematory

Cath. National

Location Trabue Rd Ext.

18 (a) Funeral director

(b) Address

644 York Rd.

SEP 24 1943

(Date rec'd by registrar)

Registrar

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1943, at 6 55 AM21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Asphyxiation
due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept. 17 1943 6 AM(b) Where did injury occur? Madison & Cathedral Sts(c) Did injury occur at home, on farm, industrial place, in public place? Knights of Columbus Hall While at work? No(d) Means of injury Hanged self with rope23. Signature Robert L. Graham M.D.Date signed Sept. 19 1943

441446
G 08474BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08474
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

DAVID Yingling

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-13-36

8. AGE:

Years

Months

Days

If less than one day

7

4

10

hr.

min.

9. Birthplace

PA.

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

12. Name

GROVER Yingling

13. Birthplace

PA

14. Maiden Name

McKinney

15. Birthplace

PA

16 (a) Informant

JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept 27 43
(month) (day) (year)

(c) Cemetery or crematory

Location: Gettysburg, PA.

18 (a) Funeral director

(b) Address

H. J. Jones & Co.

19 (a)

(b)

SEP 24 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

PA

(b) County

(c) City or town

Gettysburg

(If outside city or town limits, write RURAL and give town)

(d) Street No.

RD 1

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 23 1943. 10:40 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept 17 1943 to Sept 23 1943.
and that I last saw him alive on Sept 23 1943.

Immediate cause of death

Brain Tumor

Due to

Due to

Other Conditions

(Include pregnancies within 2 months of death)

Date of operation

Sept 23, 43

Major findings of operation: Cerebral
edema. Tumor NOT found in
Cerebellum.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

A. E. Bowler

Address

Johns Hopkins Hosp

Date signed Sept 24 1943

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

G 08475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08475

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery and crematorium

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22, 1943, to Sept. 23, 1943, and that I last saw him alive on Sept. 22, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1207 N. Caroline

Date signed 24-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death in plain language.

SEP 24 1943

VS 1

Huntington Williams, M.D.

Registrar

G 08476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08476

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *117 S. Payson Street*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *20*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Mary K. Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

Clarence Campbell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 3, 1878

8. AGE:

Years

Months

Days

If less than one day

*65**6**20*

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

John Hamilton Gray

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Margaret Lott

15. Birthplace

Baltimore, Md.

16 (a) Informant

George R. Gray

(b) Address

35 Glenwood Ave, Catonsville

17 (a)

Burial

(b) Date thereof

9-25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore, Maryland

18 (a) Funeral director

George F. Johnson

(b) Address

2101 Frederick Avenue

(c)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

117 South Payson Street

(e) Citizen of foreign country?

(If registered)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 23**1943*21. I certify that death occurred on the date above stated, that I attended deceased from *July 1943* to *Sept 23, 1943*.and that I last saw *her* alive on *July 23, 1943*.

Immediate cause of death

Retro-pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Benjamin Miller

M. D.

Address

2030 Wilkins

Date signed

9/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every statement made on this certificate is subject to investigation. Physicians: please write the causes of death clearly and legibly.

SEP 24 1943

VS 150

G 08477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08477
Registered No.

102

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1533 E. Monument**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Millburn Bell

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male**Black****Widowed**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **5-27-56**

8. AGE: Years Months Days If less than one day

57**3****26****hr.****min.**

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

dry cleaning

11. Industry or business

12. Name **Simon Bell**

13. Birthplace

Md14. Maiden Name **Laura Smith**

15. Birthplace

Md16 (a) Informant **Records**

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) **Burial** (b) Date thereof **9-27-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Not always known**
Location **Brooklyn, B. & O. Md**18 (a) Funeral director **Mrs. Ida Bailey**(b) Address **1421 Jefferson St.**19 (a) **24 1943** (b) **Huntington Williams, M.D.**
(d by registrar) Registrar

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 23 1943** **2:00 P.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 20 1943** to **Sept 23 1943** and that I last saw him alive on **Sept 23 1943**.

Immediate cause of death

**Uremia
Cardiac Failure**

Due to

Due to **Malignant Hypertension**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **J. E. Duncan Jr.**
Address **H H** Date signed **9-24-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Thelma Charlton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11-9-35

8. AGE:

Years

Months

Days

If less than one day

7

10

15

hr.

min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual Occupation

Chad

11. Industry or business

FATHER
MOTHER

12. Name

Frank Charlton

13. Birthplace

Va

14. Maiden Name

Etta Summer

15. Birthplace

Va

16 (a) Informant

Recorder

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Sept 27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

West Pa

Location

West Pa

18 (a) Funeral director

West Pa

(b) Address

West Pa

19 (a)

West Pa

West Pa

2. USUAL RESIDENCE OF DECEASED:

(a) State

Pa

(b) County

(c) City or town

Oxford

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

Rt. 2 Box 155

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 24 1943 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1943 to Sept 24 1943, and that I last saw him alive on Sept 24 1943.

Immediate cause of death

Brain Abscess

Duration

? 1 mo

Due to

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

9-24-43

Major findings of operation:

Brain Abscess

of autopsy:

Brain Abscess

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Henry V. Ryznar

Address

Johns Hopkins Hospital

Date signed

9-24-43

SEP 25 1943

88179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08479

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date of removal

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

at

9:24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from

9/14

1943

to 9/24

1943

and that I last saw him alive on

9/24

1943

Immediate cause of death

Art. C. V. D. with

myocardial degeneration

Due to

Due to

Other Conditions

Benign Prostatic

Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

9/21/43

Major findings of operation

Benign

Prost. Hypertrophy

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 25 1943

VS 150

08480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08480
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga St*

(c) Hospital or institution:

Mercy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *40 days*(e) Length of stay in Baltimore (yrs., mos., or days) *40 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *-*(c) City or town *Balt.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *730 Newington Ave*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Girl Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 16, 1943*

8. AGE: Years Months Days If less than one day

*0**1**10**8*

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name *John S. Perkins*13. Birthplace *Va*14. Maiden Name *Luella Ramsay*15. Birthplace *W. Va.*16 (a) Informant *Mr. John S. Perkins*(b) Address *730 Newington Ave*17 (a) *Burial* (b) Date thereof *9-25-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *St. Peter's*Location *3300 Mt. Vernon*18 (a) Funeral director *George G. Fisher*(b) Address *Fulton & Fayette*19 *SEP 25 1943* *Huntington Williams, Md.*

(Date and by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 24, 1943*, at *1:25 PM*21. I certify that death occurred on the date above stated that I attended deceased from *Aug 23, 1943*, or *Sept 24, 1943*, and that I last saw her alive on *Sept 23, 1943*.

Immediate cause of death

Resp. Failure

Duration

*-*Due to *Respiratory (non-specific)**8 days*Due to *Dehydration & Acidosis**3 days*Other Conditions *Prematurity*

PHYSICIAN

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Underline the cause to which death should be charged statistically.

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Robert B. Thurney*Address *Mercy Hosp* Date signed *9/24/43*

08481 1506

GATTON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G 08481

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Saratoga & Calvert*

(c) Hospital or institution:

mary hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *26*(e) Length of stay in Baltimore (yrs., mos., or days) *12***2. USUAL RESIDENCE OF DECEASED:**(a) State *md* (b) County *Balto*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Calvert & Saratoga**2500 Cowley Lane* (If rural give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME*Isabel Bay Sallou to 1*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/22/43

8. AGE:

Years

Months

Days

If less than one day

2 hr.*12* min.

9. Birthplace

Baltimore md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Arthur Galton

13. Birthplace

Balto, Md.

14. Maiden Name

Mary Rappold

15. Birthplace

Balto, Md.

16 (a) Informant

Mrs Mary I Galton

(b) Address

2500 Cowley Lane, Balto, Md.

17 (a)

Burial

(b) Date thereof

9 25 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Peters

Location

Balto, Md.

18 (a) Funeral director

George A. Farley

(b) Address

Fulton & Fayette

19 (a)

*SEP 25 1943**Washington Williams*

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9/23*19*43* at *12* *PM*21. I certify that death occurred on the date above stated; that I attended deceased from *9/22/43* 19*43*, to *9/23* 19*43*, and that I last saw him alive on *9/23* 19*43*.

Immediate cause of death

Duration

Due to

Premature

Due to

Birth

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

L. B. English

Address

Date signed

M. D.

9/23

G 08482

GATTON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G 08482
Registered No.**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address *Columb & Saratoga*

(c) Hospital or institution:

Mercy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 mo 5*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:(a) State *md.* (b) County *Balto.*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2500* *Bowling Lane*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME*Body Bay Gattton #2*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or divorced *3*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *9/22/43*

8. AGE: Years Months Days If less than one day

2 hr. *5* min.9. Birthplace *Mercy Hospital, Balto., Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Arthur Gattton*13. Birthplace *Balto., Md.*14. Maiden Name *Mary Reynolds*15. Birthplace *Balto., Md.*16 (a) Informant *Mrs. Mary Gattton*(b) Address *2500* *Bowling Lane* *Balto.*17 (a) *Burial* (b) Date thereof *9 25 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Peter's*Location *Balto., Md.*18 (a) Funeral director *George A. Farley*(b) Address *Fulton & Fayette*19 *SEP 25 1943* *Washington, D.C.*

VB 168

MEDICAL CERTIFICATION20. DATE OF DEATH *9/23/43* 19*43*, at *12* *PM*21. I certify that death occurred on the date above stated; that I attended deceased from *9/22* 19*43*, to *9/23* 19*43*, and that I last saw him alive on *9/23* 19*43*.

Immediate cause of death

Duration

Due to *Granuloma*Due to *Buth*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *J. R. Sigler*Address *Mercy Hospital*Date signed *9/23/43***PHYSICIAN**

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08483

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 25 1943

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/43 19 at 11:29 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1943 to 9/23 1943 and that I last saw him alive on 9/23 1943.

Immediate cause of death

Aspiration & Atelectasis ??

Due to

Whooping cough
Cerebral atrophy

Due to

Dehydration

Other Conditions

Infection

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Cohen

Address

Univ. Hosp

Date signed

9/24/43

Duration

2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08484

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

930 W. Franklin St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ben Love

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 8, 1903

8. AGE:

Years

Months

Days

If less than one day

X0

1

13

hr.

min.

9. Birthplace

Virginia

10. Usual Occupation

Porter

11. Industry or business

FATHER

12. Name

Benj. Love

13. Birthplace

Charlotte, Va.

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

Mr. Harry Hopkins
930 W. Franklin St.

17 (a)

Burial

(b) Date thereof

9-25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Mt. Auburn Cem.

Location

Baltimore, Md.

18 (a) Funeral director

(b) Address

Mr. Francis A. Hemmley

19 (a)

SEP 25 1943

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-21-1943, 5:05 P.M.

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Aortic insufficiency
Myocardial Pseudotumor

Due to

Other Conditions

Myocardial infarction &
Heart

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Howard J. Mulderis

M.D.

Date signed 9-22-43

Medical Examiner.

G 08485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08485
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **526 N. Eden St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **526 N. Eden St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Elise Johnson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored6 (a) Single, married, widowed, or
divorced.**Widowed**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1871

8. AGE:

Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace **Baltimore, Md.**

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Chase

13. Birthplace

Md.

14. Maiden Name

Cassie Smith

15. Birthplace

Md.

16 (a) Informant

Mamie Johnson

(b) Address

526 N. Eden St.17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof

9/25/43

(month) (day) (year)

(c) Cemetery or crematory

St. Stevens

Location

Middle River, Md.

18 (a) Funeral director

Elroy O. Wilson

(b) Address

1000 Brantley Ave.

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 221943. **22** **A.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 17** 1943, to **Sept 22** 1943, and that I last saw him alive on **Sept 21** 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward Fisher

Noted

? Monument Street 9/25/43

SEP-25 1943

CERTIFICATE OF DEATH

G 08486

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County _____

(4) City or town **Baltimore**

() City or town _____
(If outside city or town limits, write RURAL and give town)

(d) Street No. **20 S. Bethel St.**

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country USA

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1943, at 24 M

3 (c) Social Security Account No.

5. Color or race
Colored

6 (a) Single, married, widowed, or divorced. **Single**

6 (c) If alive, give age years

August 12, 1900

8. AGE: Years	Months	Days	If less than one day	
43	1	11	hr.	min.

(Town, county, and state):

11. Industry or business

13. Birthplace

15. Birthplace

(b) Address 20 S. Bethel St.

17 (a) **Burial** (b) Date thereof **9/27/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location _____

(b) Address - 1000 Brantley Ave.

19 (a) _____ (b) He is not Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1943, at 2³⁰ A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1943 to Sept 7 1943 and that I last saw him alive on Sept 7 1943.

Immediate cause of death Trish

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence _____ at _____ N

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(c) Means of inju

23. Signature James A. Woodman

Address W.D. Woodbury Date signed Sept 24

Duration

Sept 6
1917

1243

PHYSICIAN

Underline the cause to which depth should be charged statistically.

SEP 25 1943

G 08157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08487
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1519 Summer St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

William Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1884

8. AGE:

Years

Months

Days

If less than one day

59

hr.

min.

9. Birthplace

Baltimore Md.

(town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

John Hammond

13. Birthplace

Md

14. Maiden Name

Emma Sorrell

15. Birthplace

Md

16 (a) Informant

(b) Address

1002 Warner St

17 (a)

Burial

(b) Date thereof

9/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

18 (a) Funeral director

E. O. Wilson

(b) Address

1000 Bayview Ave

19 (a)

SEP 25 1943

Huntington Williams, Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1943 at 5:25 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Hypertensivecardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert A. Graham

M.D.

Date signed

Sept. 23, 1943

G 08488

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08488
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 424 S. Caroline St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Collison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married
Wife

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1876

8. AGE: Years

67

Months

Days

If less than one day

hr.

min.

9. Birthplace

Eastern shore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Laborer

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Lettie B. Johnson

(b) Address

417 S. Caroline St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 9/27/43

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Elroy O. Wilson

(b) Address

1000 Brantley Ave

19 (a)

SEP 25 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1943, at 5:15 M21. I certify that I took charge of the remains described above, held an autopsy inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Empyema, left

Due to

Lobar pneumonia, organizing

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature

Robert L. Guthrie M.D.

Medical Examiner

Date signed Sept. 23, 1943

8489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08489

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 118 E. 33rd St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LILLIE MARIE

AXT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 40

Months 1

Days 0

If less than one day

hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Ironer on collars

11. Industry or business

McInnis Laundry

12. Name

Martin L. Aft

13. Birthplace

Baltimore, Md.

14. Maiden Name

Rebecca Myers

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mrs. Albert E. Duth

(b) Address

1760 Dorsuch Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9/27/43

(c) Cemetery or crematory

Western

Location

Edmondson Avenue

18 (a) Funeral director

Clarence F. Hoffman

(b) Address

1639 N. Broadway

(c) Registrar

Huntington Williams, M.D.

Date signed

9-28-43

Registrar

SEP 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1943 at 12:40 PM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

diabetes mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. L. Wallensten M.D.Date signed 9-28-43

G 08490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08490

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1101 Division St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *17 yrs*(e) Length of stay in Baltimore (yrs., mos., or days) *25 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *—*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1101 Division St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Zack Wade

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

*Col*6 (a) Single, married, widowed, or
divorced*Married*6 (b) Name of husband or wife *Eva Wade*6 (c) If alive, give age *35* years7. Birth date of deceased (mo., day, yr.) *8-10-1900.*

8. AGE:

43

Years

1

Months

13

Days

If less than one day

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER12. Name *Sandy Wade*

13. Birthplace

*Va*14. Maiden Name *Katie ?*

15. Birthplace

*Va*16 (a) Informant *Eva Wade*(b) Address *1101 Division St*17 (a) *Burial* (b) Date thereof *9-23-43*

(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment *St. Albans Church*Location *Baltimore MD*18 (a) Funeral director *William A. Tucker*(b) Address *916 Pennsylvania Ave*19 (a) *SEP 25 1943* Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/23* 19*43* at *10:00* M21. I certify that death occurred on the date above stated that I attended
deceased from *7/10* 19*43* to *9/23* 19*43*
and that I last saw him live on *9/22* 19*43*.

Immediate cause of death

*Chronic pulmonary
infection*

Duration

months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information given
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08491
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

(m) Address

(n) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended
deceased from Sept. 23 1943. to Sept. 23 1943.
and that I last saw him alive on Sept. 23 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 25 1943

JL- 19420 08492

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08492

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 10 - 11

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 528 Central Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

Elsworth Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lucy (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1860?

8. AGE: Years 82 ? Months 11 ? Days 24 ? If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

12. Name Lloyd

13. Birthplace ?

14. Maiden Name Rose

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 25 - 1943 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Location Annapolis, Md

18 (a) Funeral director Byrd & Son, Inc.

(b) Address 721 Chesapeake St

19 (a) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1943 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 9/24 1943 and that I last saw him alive on 9/24 1943

Immediate cause of death

Due to A. S. C. V. disease
card. failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

cardiac hypertrophy; arteriosclerosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sugman M.D. Address B C H Date signed 9/24

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 25 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08493

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3011 Dylston Road city

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Henry Harrison Daub (Mary) (MARY E. DAUB)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

widow

6 (b) Name of husband or wife Harry H. Daub

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1870

8. AGE: Years Months Days If less than one day

72

9

7

hr.

min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Carl Lassahn

13. Birthplace Germany

14. Maiden Name Amelia Powell

15. Birthplace Germany

16 (a) Informant Mrs. S. Rauschenbach

(b) Address 3011 Dylston Road, City

17 (a) (b) Date thereof 9/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

SEP 25 1943 (b) Hustington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1943, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943, to Sept 24 1943, and that I last saw her alive on Sept 24 1943.

Immediate cause of death
Pneumonia

Due to

Due to

Other Conditions Pericarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury G.M. Foster

23. Signature

Address

Date signed 9-27-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1226 S Hanover
G. 08494
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 29 Bristol Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore MD
(If outside city or town limits, write RURAL, and give town)(d) Street No. 29 Bristol Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war.

3 (c) Social Security Account

No. 217-09-7992

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife Aldora L. Pumphrey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17-1880

8. AGE: Years Months Days If less than one day

63 68 - - 7 hr. min.9. Birthplace Anni Anundel County
(Town, county, and state)10. Usual Occupation Floor Finisher

11. Industry or business

12. Name Greenbury Thomas Pumphrey13. Birthplace Anni Anundel County14. Maiden Name Margaret Ann Upston15. Birthplace Anni Anundel County16 (a) Informant Mr Paul Collofflower(b) Address 29 Bristol Ave17 (a) Glen Haven Cem (b) Date thereof Sept 27-43
(Burial, cremation, or other) (month) (day) (year)(c) Cemetery or crematory Burial Glen Haven Cem.Location Glenburnie Md18 (a) Funeral Director Milton Schilling(b) Address 3914 S. Hanover St19 (a) Huntington Williams, Md (b) Registrar

SEP 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 - 1943, at 11:05 AM21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/ 1943, to 9/24/ 1943.and that I last saw him alive on 9/23/ 1943.

Immediate cause of death

- Pulmonary Tuberculosis

Duration

7

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry SeilerAddress 1226 Hanover St. Date signed 9/25/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08495

BALTIMORE CITY HEALTH DEPARTMENT

G 08495

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1341 Homestead St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1341 Homestead St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Luella M. Marshall

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife L. J. Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th 1861

8. AGE: Years Months Days If less than one day

82

2

12

hr.

min.

9. Birthplace Bath Creek, Michigan

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

Self

12. Name Newman E. Cole

13. Birthplace N. Y. State

14. Maiden Name Jane Keith

15. Birthplace N. Y. State

16 (a) Informant Walter K. Marshall

(b) Address 1341 Homestead St.

17 (a) Cremation (b) Date thereof Sept 25th 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto Md

18 (a) Funeral director William Gok Inc

(b) Address 1217 St Paul St.

19 (a) SEP 25 1943 (b)

Registrar

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23rd 1943 at 2³⁰ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1943 to Sept 23 1943, and that I last saw her alive on Sept 22 1943.

Immediate cause of death.

Edema of Lungs

Due to

Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. G. Hall

Address 1631 E. North Ave Date signed 9/27/43

Duration

1 day

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH CORRECTING INK. Every item on this form is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

88496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

G 08496

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4207 Elderson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

28

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Sylvan M. Abbott

3 (b) If veteran, name war

3 (c) Social Security Account

213-05-0217

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ira S. Abbott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 11/1885

8. AGE:

Years

Months

Days

If less than one day

58

5

14

hr

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

General Clerk

11. Industry or business

Daniel Muller Co.

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Mrs Richard P. Sadler

(b) Address

4207 Elderson Ave

17 (a)

Burial

(b) Date thereof

Sept 28/1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hoodlough

Location

Hoodlough Md

18 (a) Funeral director

Harry R. Umack

(b) Address

4207 Elderwood Ave

19 (a)

SEP 25 1943

Huntington Williams

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4207 Elderson Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 28 1943 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from first year to September 28 1943, and that I last saw him alive on September 19 1943.

Immediate cause of death

Acute Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

N.E. Needle M.A.

23. Signature

Address 2314 - 77. North Ave. Date signed 9/29/43.

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information shown is carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08497

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10/43 to Sept. 24/43, and that I last saw him alive on Sept. 24/43.

Immediate cause of death

Duration

Arterio-Sclerosis.

Unknown.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

PLEASE WRITE PLAINLY, WITH CORRECT SPELLING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08498

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ANNA TRESSLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife **CHARLES**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **8-8-78**

8. AGE: Years Months Days If less than one day

65

1

17

hr. min.

9. Birthplace

PA
(Town, county, and state)

10. Usual Occupation **AX HOMER**

11. Industry or business

12. Name **JOSEPH WERT**

13. Birthplace

14. Maiden Name **MARY HEIRICK**

15. Birthplace

16 (a) Informant

RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) **Removal** (b) Date thereof **Sept 25-78**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Newport Pa
Pennsylvania

18 (a) Funeral director

(b) Address

1217 SE Paul St

19 (a) (b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **PA** (b) County

(c) City or town **Newport**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **R.F.D. 1**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 25 1943** at **450** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 24 1943** to **Sept 25 1943**, and that I last saw him alive on **1943**

Immediate cause of death

Cerebral accident

Due to

arteriosclerosis

Due to

Other Conditions **auricular fibrillation**
meningitis - ? septic
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **not reported**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

John R. Birmingham

Address

J H H

Date signed **9-25**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

VC 08499 Sd 2168

Registered No.

938 Max Sobel

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 115 S Regester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S Regester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Luther Price

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 401-01-7460

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mae

6 (c) If alive, give age

47 years

7. Birth date of deceased (mo., day, yr.)

Feb 24 1889

8. AGE:

Years

Months

Days

If less than one day

54

6

29

hr. min.

9. Birthplace

Tenn.

10. Usual Occupation

Elect. Helper.

11. Industry or business

FATHER

MOTHER

12. Name John Price

13. Birthplace NY

14. Maiden Name Margaret Goodman

15. Birthplace Tenn.

16 (a) Informant

Mae Price

(b) Address

115 S. Regester St

17 (a)

removal

(Burial, cremation, or removal)

(b) Date thereof

9/25/43

(month) (day) (year)

(c) Cemetery or crematory

Location

East Stone Gap, Va.

18 (a) Funeral director

M. N. K. Dippel's Sons

(b) Address

1005 1/2 N. 1st St.

19 (a)

SEP 25 1943

VB 124

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 23 1943

at 9:20 M

21. I certify that death occurred on the date above stated that I attended deceased from

Jan 11 1943

and that I last saw him alive on

Immediate cause of death

Cerebral Hemorrhage

Due to Cardiovascular

Due to Aneurysm

Other Conditions

and Cardiac Disturbances

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. Williams

Physician

Underline the cause to which death should be charged statistically.

Duration

9 hr

Physician

Underline the cause to which death should be charged statistically.

Duration

9 hr

Physician

Underline the cause to which death should be charged statistically.

Duration

9 hr

Physician

Underline the cause to which death should be charged statistically.

Duration

9 hr

Physician

G 08500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08500
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 502 N. Fayette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edith E. Curlee

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-20-6913

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1914

8. AGE: Years Months Days If less than one day

28 11 15 hr. min.

9. Birthplace Healing Springs N.C.

(Town, county, and state)

10. Usual Occupation Reflector11. Industry or business Koppers Co.12. Name Frank M. Curlee13. Birthplace N.C.14. Maiden Name Maudie Smith15. Birthplace N.C.16 (a) Informant Mrs. Mabel Levine(b) Address 502 N. Fayette St.17 (a) Removal (b) Date thereof 9/26/42

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or burying place Landis

Location

18 (a) Funeral director William Cook(b) Address 1217 St. Paul St19 (a) SEP 25 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1942 at 10 P.M.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute benzene Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 9-28-42 at 10 P.M.(b) Where did injury occur? 502 N. Fayette St(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no(d) Means of injury Taken by mis take internally.23. Signature Horace J. Childers M.D.Date signed 9-28-43 Medical Examiner.

correct age is especially important

SEP 25 1943 Huntington Registrar

G 08501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08501

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1911 E. 31st St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louis E. Hayes

3 (b) If veteran, name war

10

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Anna L. Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 1st 1881

8. AGE:

Years

Months

Days

If less than one day

62

0

22

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

Nichols & Stone Co

12. Name

Louis E. Hayes

13. Birthplace

Va.

14. Maiden Name

Annie Grot

15. Birthplace

Greenough

16 (a) Informant

Anna L. Hayes

(b) Address

1911 E. 31st St.

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

9/27/43

(c) Cemetery or crematory

Greenough

Location

Balto Md

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

Date of registration

25-1943

VB 136

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1911 E. 31st St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 23rd 1943 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1943 to Sept 23 1943.

and that I last saw him alive on Sept 22 1943.

Immediate cause of death

Uremia

Due to arteriosclerotic

cardio-renal disease

Due to

Other Conditions Apoplexy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

R. B. Sybert

M. D.

Address 2807 Harford Rd

Date signed 9-24-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08502
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calhoun + Fayette St.*

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. *611 E. 33rd Street*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Emma Shone

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. *DATE*

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or

divorced

Widowed(b) Name of husband or wife *George H. Shone*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 5th 1865*

8. AGE:

Years

78

Months

0

Days

20

If less than one day

hr.

20

min.

9. Birthplace

Balto. Md

10. Usual Occupation

housewife

11. Industry or business

at home

12. Name

William H. Fleming

13. Birthplace

Unknown

14. Maiden Name

Martha Ann Lancaster

15. Birthplace

Unknown

16 (a) Informant

Howard F. Shone

(b) Address

*Crownsville Md.*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

9/27/43

(month) (day) (year)

(c) Cemetery or crematory

Balto

Location

Md

18 (a) Funeral director

Wm. Cook & Co.

(b) Address

1217 St. Paul St.

19 (a)

Huntington Milliam

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-25* 19*43*, at *M*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Generalized Cancer

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Joseph H. Laukaitis*Address *Franklin Square*

Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 25 1943

08503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08503

Registered No.

50

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 617 Winans Way(c) Hospital or institution: Hunting Ridge(d) Length of stay in hospital or inst. (yrs., mos., or days) 28(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

Nellie E. Yagle

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. 212-03-6085

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife John C. Yagle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23rd 1886

8. AGE:

56

Years

Months

11

Days

21

If less than one day

hr.

min.

9. Birthplace

Caroline Co. Md.

(Town, county, and state)

10. Usual Occupation

Clerk11. Industry or business C-P Telephone Co.

12. Name

John S. Graser

13. Birthplace

Md.

14. Maiden Name

Mary Emma Osborne

15. Birthplace

Md.

16 (a) Informant

John C. Yagle

(b) Address

617 Winans Way

17 (a)

Burial

(b) Date thereof

9/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Co. Md.

18 (a) Funeral director

William Cook & Co.

(b) Address

1217 St. Paul St.

19

SEP 25 1943(b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

617 Winans Way

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 24th 194321. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1943 to Sept 24 1943, and that I last saw her alive on SEPT 23 1943.

Immediate cause of death

CARCINOMA OF BREASTWITH METASTASES TO LIVER

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Radical Breast

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: ND

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward F. Milan

Address

682 Washington St.Date signed 9-25-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08504

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1 N. Ellwood Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1 N. Ellwood Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

James L. Wilkinson

3 (b) If veteran, name war

10

3 (c) Social Security Account

No. *LINE*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Jan '7 - 1878*

8. AGE:

Years

Months

Days

If less than one day

*65**8**6*

hr.

min.

9. Birthplace

Balto. Md.

10. Usual Occupation

Retired Brakeman

11. Industry or business

Sparrows Point Co.

FATHER

12. Name

James L. Wilkinson

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Sallie Kimball

15. Birthplace

Balto. Md.

16 (a) Informant

Albert H. Wilkinson

(b) Address

1 N. Ellwood Ave

17 (a)

Burial

(b) Date thereof

9/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Olive

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

SEP 25 1943

(Date filed by registrar)

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept 23 - 1943 at J.P. M*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 20 1943* to *Sept 23 1943*, and that I last saw him alive on *Sept 23 1943*.

Immediate cause of death

Cerebral hemorrhage

Duration

Due to

Arterio Sclerosis

Due to

Chronic Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles A. Anderson

M. D.

Address

3001 Hammond Ave

Date signed

9/24/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MENSING
G 08505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08505
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Caton + Wilkens Ave*
(c) Hospital or institution: *St Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *22 d.*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Maryland* (b) County *Baltimore*
(c) City or town *Halethorpe*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *4504 Ridge Ave*
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Elizabeth Mensing

3 (b) If veteran, name war

NU

3 (c) Social Security Account

No. *46E*

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Charles Mensing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12/3/80

8. AGE: Years

61 62

Months

9

Days

21

If less than one day

hr.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual Occupation

housewife

11. Industry or business

at home

12. Name

Thomas (Lanz) Krissner

13. Birthplace

Germany

14. Maiden Name

Hakowicz

15. Birthplace

Germany

16 (a) Informant

Chas. Mensing

(b) Address

4504 Ridge Ave Halethorpe Md

17 (a)

Burial

(b) Date thereof

9/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Pauls

Location

210 Ketsville Rd.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

SEP 25 1943

(b)

Huntington Williams, M.D.

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/24

19 *43*

at *9:05 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/2* 19 *43*, to *9/24* 19 *43*, and that I last saw her alive on *9/24* 19 *43*.

Immediate cause of death

Peritonitis

Due to

Anastomosis bowel for ca. 7

Due to

Other Conditions

Possible cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

9/16/43

Major findings of operation:

ca of sigmoid colon.

of autopsy:

Peritonitis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Howard W. Stier

Address

St Agnes Hospital

Date signed

9/24/43

G 08506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08506

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave

(c) Hospital or institution:

Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Amanda Elizabeth Dickinson

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Joseph H. Dickinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 25 - 1864

8. AGE: Years Months Days If less than one day

79 1 - hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

12. Name Frederick H. Baker

13. Birthplace Md.

14. Maiden Name Mary Catherine Prescott

15. Birthplace Md.

16 (a) Informant Earlyn H. Dickinson

(b) Address 4021 Roland Ave

17 (a) Burial (b) Date thereof 9/25/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar)

SEP 25 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No 4021 Roland Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1943 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Aug 5 1941 to Sept. 25 1943.

and that I last saw her alive on Sept. 25 1943.

Immediate cause of death

Cardio-renal-Vascular

Disease

Due to

Due to Myocardial Insufficiency 1 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J N Wilson

Address 617 N. 40th St

Date signed 9/25/43

Duration

2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J N Wilson

Address 617 N. 40th St

Date signed 9/25/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08507

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 25 1943

VB 144

Registrar

G 08508

BALTIMORE CITY HEALTH DEPARTMENT

G 08508

Registered No.

CERTIFICATE OF DEATH

83

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4613 N. Ngata Ave.

(c) Hospital or institution:

Int. Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

35 years

3 (a) FULL NAME

Sophie Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1872

8. AGE:

Years

Months

Days

If less than one day

71

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

house wife

11. Industry or business

12. Name

Samuel Weinstein

13. Birthplace

Russia

14. Maiden Name

Rebecca

15. Birthplace

Russia

16 (a) Informant

Hyman S. Schwartz

(b) Address

3820 Fairview Ave

17 (a)

Burial

(b) Date thereof

9-26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rosedale

Location

Ph. Rd.

18 (a) Funeral director

Joseph Lewis Inc.

(b) Address

1839 E. Baltimore St.

(c) Date rec'd by registrar

SEP 25 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3820 Fairview Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-25-43

19

5:30

A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1939 to Sept. 25 1943, and that I last saw him alive on Sept. 25 1943.

Immediate cause of death

arterio Sclerosis

Thromboplegia

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

N. A. Michelson

M. D.

Address

Date signed

9/26/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08509

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Belvedere Green Spring Ave*
 (c) Hospital or institution: *Perindale*
 (d) Length of stay in hospital or inst. yrs., mos., or days *27*
 (e) Length of stay in Baltimore (yrs., mos., or days) *50*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Ind.* (b) County
 (c) City or town *Balti*
 (d) Street No. *Perindale*
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 25* 1943, at *11:30 P.* M

21. I certify that death occurred on the date above stated; that I attended deceased from 19. to 9 25 1943.

and that I last saw her alive on 9 25 1943.

Immediate cause of death.

Coronary thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

G 08510

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County B
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2666 Osage Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

HARRY LIPSCH
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife MAE LIPSCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 10, 1887

8. AGE: Years 56 Months 3 Days 15 If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name HARRIS LIPSCH.

13. Birthplace RUSSIA.

MOTHER 14. Maiden Name MARY GOMALSKY

15. Birthplace RUSSIA.

16 (a) Informant Wife

(b) Address

17 (a) Burial (b) Date thereof 9-26-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wash Rd.

Location same

18 (a) Funeral director John Lewis Inc.

(b) Address 1439 E. Balto St.

19 (a) (b)

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1943, at 7:15 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/24 1943, to 9/25 1943, and that I last saw him alive on 9/25 1943.

Immediate cause of death Cerebro-vascular Accident

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. Queen

Address Long Hosp. Date signed 9/25/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED, WITH CORRECTING FLUID. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

SEP 26 1943

G 08511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08511

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4022 WOODHAVEN AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

MARK RHODE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

SEPT. 9-1943

8. AGE:

Years

Months

Days

If less than one day

16

hr.

min.

9. Birthplace

BALTIMORE, MD

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER
MOTHER

12. Name

MAURICE RHODE

13. Birthplace

BALTIMORE, MD.

14. Maiden Name

RUTH SCHWARTZ

15. Birthplace

BALTIMORE, MD

16 (a) Informant

FATHER

(b) Address

4022 WOODHAVEN AVE

17 (a)

BURIAL

(b) Date thereof

9-26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

WINDSOR HILL RD

Location

SAME

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1439 E. BALTIMORE ST

19 (a)

10-1-43

(Date filed by registrar)

Washington, D.C.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD.

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4022 WOODHAVEN AVE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-25-

1943, at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10, 1943, to Sept 25, 1943, and that I last saw him alive on 9/18/43

Immediate cause of death

Cerebral hemorrhage

Due to

Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

2200 Park Ave

Date signed

9/25/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C 08512

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Madison & Fiske*
- (c) Hospital or institution: *Mad. Gen. Hosp.*
- (d) Length of stay in hospital or inst. (yes, mos. or days) *9/17/43 to 9/25/43 11*
- (e) Length of stay in Baltimore (yrs. mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County *Baltimore*
- (c) City or town *Dundalk MD*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *8135 Bullneck Rd.*
(If rural give location)
- (e) Citizen of foreign country? (Yes or No) ☒
- If yes, name country

3 (a) FULL NAME

Mary Kay Reuter

3 (b) If veteran, name was

(c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/17/43

8. AGE:

Years

Months

Days

If less than one day

18

hr.

min.

9. Birthplace

Dundalk MD.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Alto Reuter

13. Birthplace

MD

MOTHER

14. Maiden Name

Irma Hawkins

15. Birthplace

MD

16 (a) Informant

Milton Reuter

(b) Address

8135 Bullneck Road

17 (a)

Burial

(b) Date thereof

Sept 27-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Darkewood

Location

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Harford Road

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9/25*1943. at *6²⁰* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *9/17* 1943. to *9/25* 1943. and that I last saw her alive on *9/25* 1943.

Immediate cause of death

SCHERBMA

Due to

Shingles & infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

L. J. Ruck

Address

MD. Gen. Hosp.

Date signed

9/25/43

PLEASE WRITE PLAINLY, WITH OBLIQUE LINE SPACING, IN INK. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. CONTACT AGE IS ESPECIALLY IMPORTANT.

G 08513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08513

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 25 1943

V8 154

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended
deceased from 9/6 1943 to 9/24 1943.
and that I last saw him alive on 9/24 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Union Hosp

Date signed 9/24/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08514

BALTIMORE CITY HEALTH DEPARTMENT

G 08514

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3021 Chesley Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Baltimore

(d) Street No.

3021

Chesley Ave

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

Cecilia B. Saraggy

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

Dec 22

8. AGE:

Years

Months

Days

If less than one day

68

9

2

hr.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

FATHER

12. Name

Wm J Saraggy

13. Birthplace

md

MOTHER

14. Maiden Name

Elizabeth Keenan

15. Birthplace

md

16 (a) Informant

Mrs Walter Norton

(b) Address

3021 Chesley Ave

17 (a)

Burial

(b) Date thereof

9-27-48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

new cathedral

Location

Leopold 9 Rueck

18 (a) Funeral director

Wm J Saraggy

(b) Address

5305 Harford Rd

19 (a)

(b) Registrar

Eugene Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 24 1948

at

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Sept 24 1948

and that I last saw him alive on

Sept 24 1948

Immediate cause of death

Myocardial infarction

Duration

7 yrs

Due to

Due to

Other Conditions

Chronic hepatitis

1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

no autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. J. Norton

Address

7101 Harford Rd

Date signed

9/24/48

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

SEP 28 1948

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

08515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08515

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1501 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

3 (a) FULL NAME

Mary C. Brendel

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Brendel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 13, 1889.

8. AGE: Years 53 Months 11 Days 9 If less than one day min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business Own Home

12. Name Joseph Hyland

13. Birthplace Ireland

14. Maiden Name Mary Rodgers

15. Birthplace Ireland

16 (a) Informant Mr. John H. Brendel (Husband)

(b) Address 1501 Holbrook Street

17 (a) Burial (b) Date thereof Sept. 17, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location 2212 E. Baltimore Ave.

18 (a) Funeral director George J. Roth, Inc.

(b) Address 1745 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1943, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27, 1943 to Sept 24, 1943, and that I last saw her alive on Sept 24, 1943.

Immediate cause of death

Wernia

Due to Hypertensive
Cardiovascular renal
disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jack F. Singer

Address 508 E. North Ave. Date signed 9-25-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 25 1943

G 68516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 68516

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3829 - YMA Ave E
(c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

3 (a) FULL NAME FRANK P. HASSE3 (b) If veteran, name war
NO3 (c) Social Security Account
No. 216 16 38624. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. MARRIED6 (b) Name of husband or wife KATIE V. HASSE
6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr) MAY 2 18818. AGE: Years 62 Months 4 Days 22 If less than one day hr. min.9. Birthplace GERMANY
(Town, county, and state)10. Usual Occupation BOX MAKER

11. Industry or business

12. Name JOSEPH HASSE13. Birthplace GERMANY14. Maiden Name LOUISE JANESKI15. Birthplace GERMANY16 (a) Informant: KATIE V. HASSE (WIFE)(b) Address 3829 FOURTH ST.17 (a) BURIAL (b) Date thereof SEPT. 27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS ROAD18 (a) Funeral director Lilly and Zeiler, INC.(b) Address 403 S. WOLFE ST.SEP 25 1943 (b) Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3829 4th Ave E Bldg
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1943 at 7:05 M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

- (a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer, M.D.
Medical Examiner.Date signed 9-24-43

G 08517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08517
Registered No.

124B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 127 N. Patterson Park Ave
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 127 N. Patterson Park Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Lorenzo Carosella

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married6 (b) Name ~~deceased~~ wife Anna Carosella6 (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) Aug. 10 1879

8. AGE: Years Months Days If less than one day
64 1 14 hr. min.

9. Birthplace Castel Mauro Italy
(Town, county, and state)10. Usual Occupation Store keeper

11. Industry or business

12. Name Pasquale Carosella13. Birthplace Italy14. Maiden Name Teresa CarloMagna15. Birthplace Italy16 (a) Informant Anna Carosella (Wife)(b) Address 214 S. High St.17 (a) Burial (b) Date thereof Sept 27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer Cem.Location Balain Rd. Baltimore Md.18 (a) Funeral director Frank Della Noce(b) Address 52 N. Morley St.

SEP 25 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1943 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1943 to Sept. 27, 1943 and that I last saw him alive on Sept. 23, 1943.

Immediate cause of death

Coronary artery disease

Duration

6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene L. Cassano

M. D.

Address 514 Perry Lane Date signed 9/27/43

AB-10800G 08518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 08518

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **4940 Eastern Ave.**
- (c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) **14 Yrs.**(e) Length of stay in Baltimore (yrs., mos., or days) **14 Yrs.**

USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
- (c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
- (d) Street No. **?**
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Duvall

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced. **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **?-?-1868**

8. AGE: Years

75

Months

?

Days

?

If less than one day

hr.

min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation **?**

11. Industry or business

FATHER
MOTHER12. Name **?**13. Birthplace **?**14. Maiden Name **?**15. Birthplace **?**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records**17 (a) **Burial** (b) Date thereof **Sept 28, 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Calhoun**Location **Baltimore**18 (a) Funeral director **Rita Wiedefeld**(b) Address **914 Greenmount Ave**

SEP 25 1943

Stuntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/24 1943 at 11:30 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **7/1 1943 to 9/24 1943** and that I last saw him alive on **9/24 1943**.

Immediate cause of death

Undetermined
Due to A.S. C.V. Disease
Non-intermittent

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **S. Y. Sargis**Address **13 CH**Date signed **9/25**

Duration

2**1****2****1**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C8519

HEALTH DEPARTMENT—CITY OF BALTIMORE

08519

CERTIFICATE OF DEATH

1. PLACE OF DEATH

W.H. ELKIN'S COLD SPRING HOME,
CITY OF BALTIMORE: (No. COLD SPRING LANE St., Ward)

Registered No.

(If death occurred in
a hospital or institution,
give its NAME instead
of street and number.)Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S. If of foreign birth? yrs. mos. ds.2. FULL NAME MRS. ROSA WELCH(a) Residence: No. LAUREL, Md.
(Usual place of abode)St., Ward P. 2nd St. W.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. Color or Race W. 5. Single, Married, Widowed,
or Divorced (write the word) Married6a. If married, widowed, or divorced
HUSBAND Andrew Welch
(or) WIFE ofc. DATE OF BIRTH (month, day, year) SEPT. 6, 1898.7. AGE Years 45 Months — Days 20 If LESS than
1 day... hrs. or min.8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc. Housewife
9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.
10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town) Calvert County,
(State or country) Md.13. NAME FRANK SIMPSON
14. BIRTHPLACE (city or town) CALVERT COUNTY
(State or country) MD.15. MAIDEN NAME UNKNOWN
16. BIRTHPLACE (city or town) Md.
(State or country)17. INFORMANT MRS. ELLEN WELCH
(Address) LAUREL, Md.18. BURIAL, CREMATION, OR REMOVAL
Place LAUREL, Md. Date SEPT. 28, 194319. UNDERTAKER W.C. WHITE CO. INC.,
(Address) LAUREL, Md.20. SEP 25 1943
Huntington Williams, Md.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) SEPT 26, 194322. I HEREBY CERTIFY, That I attended deceased from
July 13, 1942 to Sept 26, 1942I last saw deceased alive on Sept 24, 1943. Death is said
to have occurred on the date stated above, at 8:30 p.m.The principal cause of death and related causes of
importance were as follows:cerebral hemorrhage

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the fol-
lowing:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public
place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. H. Patterson M. D.(Address) 2324 Reservoir Rd

OCCUPATION is very important. See instructions on back of certificate.

68520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08520
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

27

9

1

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 25 1943

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-24

1943, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1943 to 9-24 1943

and that I last saw him alive on 9-24 1943

Immediate cause of death: Respiratory Failure

Duration

Due to Uremia

Due to Chronic hepatitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

8521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08521
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bon Securus Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 81 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County -----

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 34 York Court
(If rural give location)(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or
divorced

Married

6 (b) Name of husband or wife

Mary V. Campbell (Dunn)

6 (c) If alive give age --- years

7. Birth date of deceased (mo., day, yr.) April 4, 1862

8. AGE: Years Months Days If less than one day
81 5 21 --hr. --- min.9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business -----

12. Name Peter Campbell

13. Birthplace Ireland

14. Maiden Name Catherine Bennett

15. Birthplace Ireland

16 (a) Informant Mrs. Mary V. Campbell

(b) Address 34 York Court

17 (a) Burial (b) Date thereof 9/28/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. W. Weeks and Son

(b) Address 805 N. Calvert Street

19 SEP 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1943, at 2⁴⁵ AM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/22/ 1943, to 9/25/1943,
and that I last saw him alive on 9/24/1943.

Immediate cause of death

Acute Myocardial Failure

Due to Pulmonary Edema

Due to Arteriosclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Richard J. Rude M. D.

Address Bon Securus Hosp Date signed 9/25/43

Duration

3 Days

3 days

?

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

522
440536

Grave # 30
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

G 08522
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **309 S. SHARP**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Edgar Pridgen**

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **6-12-05**

8. AGE: Years **38** Months **3** Days **2** If less than one day hr. min.

9. Birthplace **N.C.**
(Town, county and state)

10. Usual Occupation **CARPENTER**

11. Industry or business

12. Name **JAMES PRIDGEN**

13. Birthplace **N.C.**

14. Maiden Name **ANNA LEE SYKES**

15. Birthplace **N.C.**

16 (a) Informant **Records**

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location **PUBLIC CEMETERY SEP 25 1943**

18 (a) Funeral director **Commissioner of Health**

(b) Address

19 (a) **SEP 27 1943** **Huntington Williams, M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 14 1943** at **11:20 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 1 1943** to **Sept 14 1943**, and that I last saw him alive on **Sept 14 1943**.

Immediate cause of death **Acute cardiac decompensation.**

Due to **Rheumatic heart disease.**

Due to **Rheumatic fever**

Other Conditions **Subacute bacterial endocarditis**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy **congenital bicuspid aortic valve**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **TB Schwarz**

M. D.

Address

Date signed

G 08523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08523

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn. (b) County ?(c) City or town Blue Ridge Summit
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Norwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F 60

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1883

8. AGE: Years Months Days If less than one day

59 11 16 hr. min.

9. Birthplace Dayton, Ohio
(Town, county, and state)10. Usual Occupation kept summer resort hotel

11. Industry or business

12. Name Randolph Norwood13. Birthplace Maryland14. Maiden Name Annie Gebhart15. Birthplace Maryland16 (a) Informant Dr. John A. Loretz(b) Address Letter from Dr. Bridges (home town)17 (a) Burial (b) Date thereof Sept. 27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Loudon ParkLocation 2801 Frederick Ave.18 (a) Funeral director W. O. Mitchell(b) Address 1900 Eutaw Place19 (a) SEP 27 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1943 at 9:35 PM21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1943 to Sept 24 1943, and that I last saw her alive on Sept 24, 1943.

Immediate cause of death

Circulatory failure

Duration

Due to Thrombosis - femoral2 daysDue to Cerebral Hemorrhage2 moOther Conditions Hypertensive Heart Diseaseyear

(Include pregnancy within 3 months of death)

PHYSICIAN

Date of operation

Major findings of operations

of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John A. LoretzAddress Union Memorial Hosp. Date signed 9-27-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08524

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Greenspring & Belvedere Ave*

(c) Hospital or institution:

Hebrew Home for Aged & Infirmary(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2 yrs.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Greenspring & Belvedere Ave.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mendel Barkan

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

*white*6 (a) Single, married, widowed, or
divorced. *single*

6 (b) Name of husband or wife

1865

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

75

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Unknown

12. Name

Unknown

13. Birthplace

Russia

14. Maiden Name

Unknown

15. Birthplace

Russia

16 (a) Informant

Levendale Home

(b) Address

*Greenspring & Belvedere Ave*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Sept 27/43

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Mt. Cemetery

Location

German Hill Road

18 (a) Funeral director

Edmund Lewin

(b) Address

*4-26 W North Ave*19 *SEP 27 1943*

(b) (Date received by registrar)

Huntington Hill, Md.

*Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-26* 19*43*, at *8 P.* M21. I certify that death occurred on the date above stated; that I attended
deceased from *1-24* 19*41*, to *9-26* 19*43*,
and that I last saw him alive on *9-26* 19*43*.

Immediate cause of death

*Ch. card. vas. disease**Ch. Bronchitis*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edmund Lewin

Address

*Levendale*Date signed *9/26/43*

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 08525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08525

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 204 E Read St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 204 E Read St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME

(b) If veteran, name war

(c) Social Security Account
No.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male WhiteSingle

(b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1896

8. AGE:

Years

Months

Days

If less than one day

47

hr.

min.

9. Birthplace Binghamton N. Y.
(Town, county, and state)

10. Usual Occupation

Brick Layer

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. (a) Informant Mr. Lehou(b) Address Bay & Frederick St17. (a) Burial (b) Date thereof Sept 27 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or place of interment MorelandsLocation Taylor Ave18. (a) Funeral director Leo S. Cook(b) Address 1701-03 N. Patt Park Ave19. (a) William H. Hager SEP 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1943 at 7 A M21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1943 to 9/24 1943, and that I last saw him alive on 9/24 1943.Immediate cause of death Cardiac
decompensation & acute
dilatationDue to Myocard & AortaDue to insufficiency -
an endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harry A. McParteyAddress 37 W. Potomac St Date signed 9/24/43Duration
14 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08526

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 441 Pittings ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town 441 Pittings Ave
(If outside city or town limits, write RURAL and give town)(d) Street No. Baltimore
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John J. Bensley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr 29, 1869

8. AGE: Years Months Days If less than one day
74 4 26 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name John W. Bensley

13. Birthplace Sinter

14. Maiden Name Helen Cook

15. Birthplace Annapolis, Md.

16 (a) Informant Dorothy Myers

(b) Address 441 Pittings Ave

17 (a) Burial (b) Date thereof 9/27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory location
Charles P. Powell

18 (a) Funeral director Charles P. Powell

(b) Address 2427 Edmondson Ave

19 (a) (b)

SEP 27 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1943, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941, to Sept 1943 and that I last saw him alive on Sept 28 1943

Immediate cause of death

Cerebral Hemorrhage

Duration

2 days

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Doan Miller M.D.

Address 1225 2nd Ave Date signed 9/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 08527
Registered No.

114E

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2812 Fox St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2812 Fox St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Donnelly

Stewart

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

F

5. Color or race

C.

6 (a) Single, married, widowed, or
divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1943.

8. AGE: Years 8 Months 9 Days If less than one day
hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Howard S. Stewart

13. Birthplace Baltimore, Md.

14. Maiden Name Louella Elliott

15. Birthplace Baltimore, Md.

16 (a) Informant Howard S. Stewart

(b) Address 2812 Fox St.

17 (a) Burial (b) Date thereof Sept. 27, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

6 SEP 27 1943 (b) Huntington Williams, M.D.
(Date of death) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943 at 10 A M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Chronic
interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed Sept 26 1943
Medical Examiner.

08528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08528

441601

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 428 Hutchins Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anderson Walker

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-4-89

8. AGE: Years

Months

Days

If less than one day

54

60

2

20

hr

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Butler

11. Industry or business

FATHER
MOTHER

12. Name

George Walker

13. Birthplace

Va.

14. Maiden Name

Melinda Hickman

15. Birthplace

Va.

16 (a) Informant

Annie Anderson

(b) Address

428 Hutchins Ave.

17 (a)

Burial

(b) Date thereof

Sept. 28, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Blessent Rest.

Location

Lansdown, Md.

18 (a) Funeral director

Rev. George W. Holland

(b) Address

1631 17th St. S.W.

(c) Date rec'd by registrar

Sept. 27, 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1943, at 10 A. M.21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1943, to Sept. 24 1943, and that I last saw him alive on Sept. 24 1943

Immediate cause of death

Coronary Failure

Duration

3 mo

Due to

Arteriosclerotic Heart Disease

4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul O. Chatfield

Address

Johns Hopkins Hospital

Date signed

7/25/43

G 08529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08529
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943. 9/26 10:10 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/23 1943, to 9/26 1943,
and that I last saw her alive on 9/26 1943Immediate cause of death Rupture of
ventricle

Due to Coronary Thrombosis

Due to Atherosclerosis CVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 9/26/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

SEP 27 1943

G 08530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08530

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4013 Liberty Heights Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1527 7th St.

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Pearl Paulini Pollipof

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1887

8. AGE:

Years

Months

Days

If less than one day

56

hr. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Not Known

13. Birthplace

Russia

14. Maiden Name

Not Known

15. Birthplace

Russia

16 (a) Informant

Danie Pollipof

(b) Address

3705 Paulding Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 9-28-43
(month) (day) (year)

(c) Cemetery or crematory

Wheat. Plng

Location

Liberty Springs Rd.

18 (a) Funeral director

Junk Senior Inc

(b) Address

1439 E. Balto St

19 (a)

(b)

SEP 27 1943

VB 150

Huntington National Bank

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-43 19 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept, 1943, to Sept 26, 1943, and that I last saw her alive on Sept 26, 1943.

Immediate cause of death

Pulmonary edema

Due to Metastatic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hpt Bayless

Address 1604 W. Wilkins Ave

Date signed 9/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08531

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5605 Greenspring Ave

(c) Hospital or institution:

Carroll Home & Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 57(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 5605 Greenspring Ave
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Flora M. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED6 (b) Name of husband or wife L. B. Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/108. AGE: Years 63 Months . Days 19 If less than one day hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual Occupation Nurse

11. Industry or business

12. Name Flora M. Myers13. Birthplace Baltimore, Maryland14. Maiden Name Minnie Myers15. Birthplace Philadelphia, Pennsylvania16 (a) Informant Mrs. L. B. Myers(b) Address 5605 Green Spring Ave17 (a) Burial (b) Date thereof 9/27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Beth. Hebrew
Location Beth. Mt.18 (a) Funeral director David Sanderson - SonSEP 27 1943 Entaw Place19 (a) (b)
(Date rec'd by registrar)

Registrar

Huntington Hillside, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1943 at 2:40 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1943 to 9-25-1943 and that I last saw her alive on 9-25-1943.Immediate cause of death Bronchopneumonia

Duration

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Small right ventricle & compressed left ventricle (no septum)
of autopsy: Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Cullen

M. D.

Address Chesapeake Home & Hosp. Date signed 9-25-43

08532

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

94a ✓ G 08532
 Registered No.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 Madison Apt. Hotel,
 (b) Street address 817 St. Paul St.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) About 45 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County
 (c) City Baltimore
 (If outside city or town limits, write RURAL and give town)
 Madison Apt. Hotel,
 (d) Street No. 817 St. Paul St.
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME
 ISAAC SON COHEN.

3 (b) If veteran, name war
 3 (c) Social Security Account
 No. None

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lottie A. Cohen.
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1869.

8. AGE: Years 74 Months 1 Days 13 If less than one day hr. min.

9. Birthplace New York.
 (Town, county, and state)

10. Usual Occupation Retired Merchant.

11. Industry or business

12. Name Mark Cohen,

13. Birthplace New York.

14. Maiden Name Elizabeth Son,

15. Birthplace

16 (a) Informant Mrs. Lottie A. Cohen,

(b) Address Madison Apt. Hotel.

17 (a) Cremation (b) Date thereof 9/28/43.
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park.
 Location Balto. Md.

18 (a) Funeral director

(b) Address 1902 Eutan Place

19 (a) SEP 27 1943
 (Date)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26th. 1943. 12.30M P.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Sept 26 1943 and that I last saw him alive on Sept 25 1943.

Immediate cause of death
 Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward Thomas
 Medical Arts Bldg. Date signed 9.27.43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08533

JL - 72235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08533
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 - 21

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

3 (a) FULL NAME

Waverly Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1893

8. AGE: Years Months Days If less than one day
50 5 21 6 hr. min.

9. Birthplace Va

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name Stephen

13. Birthplace Md.

14. Maiden Name Anna ?

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/27/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or cremation St. Anthony

Location Robert F. Green

18 (a) Funeral director

(b) Address 804 N. Caroline

SEP 27 1943 18

VB 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 811 Low St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1943 at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1942, to 9-24 1943, and that I last saw him alive on 9-24 1943.

Immediate cause of death

Coronary Failure
Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Webb

Address Baltimore City Hosp Date signed 9-28-43

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physician please write the cause of death in the space provided.

G 08534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08534

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 710 Sharp St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 710 Sharp St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Louise Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female Colored

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr. 10-43

8. AGE:

Years

Months

Days

If less than one day

5

15

hr.

min.

9. Birthplace

Winchester, Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Isaac Brown

13. Birthplace

W. Va

14. Maiden Name

Elizabeth Stern

15. Birthplace

Va

16 (a) Informant

Dora Edwards

(b) Address

710 Sharp St

17 (a)

Burial

(b) Date thereof

Sept 29-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Stephens City, Va

Location

Virginia

18 (a) Funeral director

James Doyles

(b) Address

142 W. 11th St

19 (a)

SEP 27 1943

Huntington

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 25 1943 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/43 to 9/25/43, and that I last saw him alive on 9/25/43.

Immediate cause of death

acute

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

D. J. Doyles

Address

125 L St

Date signed

9/27/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08535
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address WYMAN Park Drive and 31st S.
(c) Hospital or institution: US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Bonaparte Street
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

EDGAR ELISWORTH SMITH

3 (b) If veteran, name war
WW

3 (c) Social Security Account
No. _____

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Polanka
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1899

8. AGE: Years 43 Months 11 Days 29 If less than one day
hr. _____ min. _____

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business _____

12. Name William Smith

13. Birthplace Baltimore, Md.

14. Maiden Name Ressie Moore

15. Birthplace Baltimore, Md.

16 (a) Informant Records-US Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Sept. 28/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location B lair Road

18 (a) Funeral director Charles E. Schirunek.

(b) Address 2601-03 E. Madison Street

19 (a) _____ (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1943 10:00p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1943 Sept. 24, 1943, and that I last saw him alive on Sept. 24, 1943.

Immediate cause of death

Aortic valvular heart disease
(aortic stenosis)

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: None

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature _____

Address US Marine Hospital Date signed 9/25/43
Baltimore, Md.

Duration
Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE CLEARLY, IN INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

SEP 27 1943

G 08536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08536

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

200 N. Parrish

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

3 (a) FULL NAME

Barbara Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 1949

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

James Carter

13. Birthplace

Essex Co. Va

14. Maiden Name

Pauline Brown

15. Birthplace

Va

16 (a) Informant

Pauline Carter

(b) Address

200 N. Parrish

17 (a)

Burial

(b) Date thereof

Sept 27, 1949

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion Am

Location

18 (a) Funeral director

Mrs. Kate Williams

(b)

SEP 27 1949

Schwartz St

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

200 N. Parrish

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 25 1949, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1949, to Sept 25 1949, and that I last saw her alive on Sept 24 1949.

Immediate cause of death:

Diarrhea

Duration

2 weeks

Due to

Due to

Other Conditions

Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence

at

Md

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Douglas Sheppard

Address

1431 W Franklin

M. D.

Date signed 9/27/49

G 08537

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08537
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 118 S. Calhoun St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 118 S. Calhoun St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Shatter Y. Rider

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M.

5. Color or race

W.6 (a) Single, married, widowed, or
divorced.widowed6 (b) Name of husband or wife late Mary Fme Brett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1869

8. AGE: Years Months Days If less than one day

74427

hr.

min.

9. Birthplace Maryland
(Town, county, and state)10. Usual Occupation Retired

11. Industry or business

12. Name Rider13. Birthplace Unknown

14. Maiden Name

15. Birthplace

16 (a) Informant Mr. Russell Rider(b) Address 118 S. Calhoun St17 (a) Burial (b) Date thereof Sept 27/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Rider CemeteryLocation Ann Greenleaf Co. Md.18 (a) Funeral director Harry H. Witzke(b) Address 41016 dmonson Ave19 (a) SEP 27 1943 (b) Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24-1943 10:20 AM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from May 1943 to 9-24-1943,
and that I last saw him alive on 9-21-1943

Immediate cause of death

Basal Carcinoma

Duration

1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Horris B. SchreiterAddress 54 S. Fulton Ave Date signed 9-24-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 95c

G 08538

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 207 Allendale St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 207 Allendale St.,

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

W. Wallace Addison, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-05-8733

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Carrie E. Addison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1893

8. AGE:

Years

Months

Days

If less than one day

4995

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

Bethlehem Steel Co.FATHER
MOTHER12. Name W.W. Addison, Sr.13. Birthplace Baltimore, Md.14. Maiden Name Mary Giles15. Birthplace Baltimore, Md.16 (a) Informant Mrs. Carrie E. Addison(b) Address 207 Allendale St.17 (a) Burial(b) Date thereof Sept. 28, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine ParkLocation Woodlawn, Md.18 (a) Funeral director St. Howard Strong

3207 W. North Ave.

(b) Address

19 (a) SEP 27 1943 Huntington Williams

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 19 43 at 6.53 A. M21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25, 1941 to Sept 1943 and that I last saw him alive on Sept 25, 1943

Immediate cause of death

Cardiac Insufficiency

Duration

1 mo.

Due to

Cardiac Hypertrophy
Dilatation3 years

Due to

Auricular Fibrillation

Other Conditions

Partial paralysis
Left side - from previous Cerebral Anoxia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Howard Cooper2107 Park Ave Date signed 9/25/43

08539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08539

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

918 n. Gilmore st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Wayne Ford

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-09-2261

4. Sex

male

5. Color or race

colored

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Mary Long Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

50 4 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

SEP 27 1943

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 08540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08540

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *3143 Elmora Avenue*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *9*

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *3143 Elmora Ave.*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Fritzy

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced.*widowed*6 (b) Name of husband or wife *Charles Fritzy*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 22, 1868

8. AGE:

Years *75*

Months

7

Days

3

If less than one day

hr.

min.

9. Birthplace

Bavaria, Germany
(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

12. Name

unknown

13. Birthplace

14. Maiden Name

unknown

15. Birthplace

16 (a) Informant

Louis G. Fritzy

(b) Address

*3143 Elmora Avenue*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

9/25/43
(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemed

Location

Marginal & Belair

18 (a) Funeral director

Leonard J. Quirk

(b) Address

5805 Harbor View

19 (a)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 25 1943* at *3A* M21. I certify that death occurred on the date above stated; that I attended deceased from *4-26-1943* to *9-24-1943* and that I last saw her alive on *9-24-1943*.

Immediate cause of death

Gastric Cancer

Duration

5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Milton C. Haug

M. D.

Address *2117 Belair Rd*

Date signed

9-27-43

SEP 27 1943

VS 140

Huntington Williams, M.D.

JL - 81684

G 08541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08541
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 89 days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1036 N. Dallas St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Shavers

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. ? ?

8. AGE: Years Months Days

If less than one day

80 ?

?

?

hr.

min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation D. P. W.

11. Industry or business

12. Name George Shavers

13. Birthplace N. C.

14. Maiden Name Susan ?

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 19, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location a. a. c. o.

18 (a) Funeral director Payne & Sandusky

(b) Address 1412 E. Preston St.

19 SEP 27 1943 (b) Huntingdon Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1943 at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1943 to 9/23 1943, and that I last saw him alive on 9/23 1943.

Immediate cause of death

Bronchopneumonia

Duration

9 d.

Due to

Due to

Other Conditions Diabetes mellitus; late latent lues; A.S. G.

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sigman

Address ACH

Date signed

M. P. 9/29

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. If uncertain, please estimate.

G 08542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08542
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1113 Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore, Md
(If outside city or town, write RURAL and give town)(d) Street No. 1113 Park Ave
(If rural, give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

William Tally

3 (b) If veteran, name was

3 (c) Social Security Account

8-19-61-5445

4. Sex

M

5. Color or race

B

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Talley

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

1894

8. AGE:

Years

Months

Days

If less than one day

50

51

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Horace Talley

13. Birthplace

Va

14. Maiden Name

15. Birthplace

16 (a) Informant

Frances Talley

(b) Address

1113 Park Ave

17 (a) Burial

(b) Date thereof

9/30/43.

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arboretum

Location

Md.

18 (a) Funeral director

Adolphus Halstead

(b) Address

918 Druid Hill Ave.

19 (a)

(b)

SEP 27 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

DATE OF DEATH 9/16/43 at 3 M21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 9/16/43 and that I last saw him alive on 9/14/43.

Immediate cause of death

Coronary thrombosis
Due to hypertension Throat

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at 3 M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. C. Talley

Address

307 Park Ave

Date 9/16/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 08543

CERTIFICATE OF DEATH

✓ 95c

G 08543

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 664 N Muehling St., Ward)

Length of residence in city or town where death occurred Life mos. 1 da. How long in U. S. If of foreign birth? 17 yrs. 1 mo. 1 da.

2. FULL NAME

(a) Residence: No. 664 Muehling St. Ward. (If non-resident give city or town and State)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U. S. Veteran

specify WAR

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Male 4. Color or Race Col'd 5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

4. DATE OF BIRTH (month, day, year) Sept 25, 1898

7. AGE 52 Years 51 Months - Days - If LESS than 1 day, - hrs. - min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 2/29 11. Total time (years) spent in this occupation? ?

12. BIRTHPLACE (city or town) Tolaco Md (State or country)

13. NAME John Thompson

14. BIRTHPLACE (city or town) Tolaco (State or country)

15. MAIDEN NAME Rachel Weems

16. BIRTHPLACE (city or town) Tolaco (State or country)

17. INFORMANT Waggy T Boone (Address) 664 Muehling St

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Auburn Date Sept 28, 1943

19. UNDERTAKER Adolphus H. H. H. (Address) 918 N. ...

20. FIVE SEP 27 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 25, 1943

22. I HEREBY CERTIFY, That I attended deceased from Sept 1943 to Sept 24 1943

I last saw him alive on Sept 24, 1943 Death is said to have occurred on the date stated above, at 6:00 PM

The principal cause of death and related causes of importance were as follows:

Org. cause Heart 1 yr
Other contributory causes of importance Pulmonary Disease

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

26 If so, specify

(Signed) J. H. Hornwood M. D.

(Address) 737 W. Fayette

Huntington Williams

G 08544 MJ-83924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08544
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 8 OR 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3017 Christopher Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Lona Andrew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or divorced.
Widowed

6 (b) Name of husband or wife William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 9 1973

8. AGE: Years Months Days If less than one day
70? 1 9 12? hr. min.9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Walker Byers

13. Birthplace Pennsylvania

14. Maiden Name ? McCahn

15. Birthplace Pennsylvania

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 9-30-73
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery Prosperity
Location Washington Co. Pa.

18 (a) Funeral director Leonard J. Kemp

(b) Address 5305 Vancourt Rd.

19 (a) (Date rec'd by registrar) 9/27/73

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1973 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1973 to 9/27 1973 and that I last saw her alive on 9/27 1973.

Immediate cause of death

Subarachnoid hemorrhage

Due to

Due to A-S. C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Sargman

Address B C H

Date signed 9/27

Duration

1 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED NAME OF PHYSICIAN IN SPACE PROVIDED. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

SEP 27 1973

G 08545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08545

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20-1943 to 9-23-1943, and that I last saw him live on 9-23-1943.

Immediate cause of death

Due to

Due to

Other Condition Chronic Alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Meningitis -

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE IN INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 27 1943

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

G 08546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08546
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 8 1425 Fayette St.
(If outside city or town limits, write RURAL and give town)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mamie Hicks

93356

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

black

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1926

8. AGE: Years Months Days If less than one day
17 2 16 hr. min.

9. Birthplace

M.C.

(Town, county, and state)

10. Usual Occupation

housework

11. Industry or business

FATHER

12. Name

Harris Hicks

13. Birthplace

N.C.

MOTHER

14. Maiden Name

Hattie Sneed

15. Birthplace

N.C.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/29/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

BEP 27 1843

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1943 at 12:05 A

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1943 to Sept. 23 1943, and that I last saw her alive on Sept 23 1943.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08547

MJ-83595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08547

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4240 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 914 N. Gay Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Irene Curtis

OR

Irene Curtis Tydings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1891

8. AGE: Years Months Days

If less than one day

52

4

5

17

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Robert Curtis (D)

13. Birthplace Maryland

14. Maiden Name Elizabeth Jackson (D)

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 9/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Arbutus

Location

18 (a) Funeral director Elroy Wilson

(b) Address

SEP 27 1943

(Date rec'd by registrar)

(b)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1943 at 11:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 1943 to 9/25 1943 and that I last saw him alive on 9/25 1943.

Immediate cause of death

Pulmonary TBC

Duration

1 yr

Due to

Due to

Other Conditions

Hepato-megaly

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Sargman

Address

BCH

Date signed

M.D.

9/26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08548
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 004
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(b) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 E. Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD L. MAGANN

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2- 1890

8. AGE: Years 53 Months 2 Days 25 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business

12. Name Archie Magann

13. Birthplace Va.

14. Maiden Name Sarah R. Magann

15. Birthplace Va.

16 (a) Informant J. E. Magann

(b) Address Amhurst, Va

17 (a) Reburial (b) Date thereof 9/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Amhurst Va

18 (a) Funeral director W. J. Farkley

(b) Address 1800 W. Fayette St

Huntington Williams, M.D.

SEP 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943, at 2 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were: IMMEDIATE CAUSE OF DEATH.

Chronic alcoholism

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. J. Farkley Medical Examiner.

Date signed 9-27-43

G 08549 CERTIFICATE CORRECTED 8.2.50 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered G 08549

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Balto. Md.

(c) Hospital or institution:

West Balto. General

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 HRS?

2. USUAL RESIDENCE OF DECEASED:

(a) State Penna. (b) County(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)(d) Street No. 938 Olvey Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Line. Alfred J. Hattman

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

m

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 1917

8. AGE: Years Months Days If less than one day

263

hr.

min.

9. Birthplace PHILADELPHIA, PA.

(Town, county, and state)

10. Usual Occupation SOLDIER11. Industry or business U.S.A.12. Name ALFRED J. HATTMAN13. Birthplace PA.14. Maiden Name ELIZABETH A. FUCHS15. Birthplace PA.16 (a) Informant ALFRED J. HATTMAN (FATHER)(b) Address 938 OLVEY AVE. PHILA. PA.17 (a) BURIAL (b) Date thereof SEPT. 30/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory BELLEVUE CEM.Location BELLEVUE PA.18 (a) Funeral director Willis J. Zeiler inc.(b) Address 403 S. MOORE ST.19 (a) 9/26/43 Wm. J. Williams, M.D.
(Date rec'd by registrar) (Registrar)MEDICAL CERTIFICATION 43 P.20. DATE OF DEATH Sept. 26 1943, at 4:10 M.21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept 26 - 1943 8:17 A.M.(b) Where did injury occur? West of Walnut - 2nd St. Phila.(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No(d) Means of injury Struck by auto.23. Signature W. J. Williams, M.D.Date signed Sept. 27, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. - Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08550
920 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **5258 Nelson Avenue**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) **2 1/2**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **5258 Nelson Avenue**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Laura L. Biggs3 (b) If veteran **666** war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

W.6 (b) Name of husband or wife **Calvin M. Biggs**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 16, 1899**

8. AGE: Years Months Days If less than one day

84**7****10**

hr.

min.

9. Birthplace **Frederick County Maryland**

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

none

FATHER

12. Name **David Hargett**13. Birthplace **Frederick County Maryland**

MOTHER

14. Maiden Name **Lydia Wren**15. Birthplace **Frederick County Maryland**16 (a) Informant **Mrs. Kattie Wright**(b) Address **5248 Nelson Avenue**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **9-28-43**

(month) (day) (year)

(c) Cemetery or crematory **Lorraine Cemetery**Location **Woodlawn Maryland**18 (a) Funeral director **LORING BYERS**(b) Address **5005 Park Heights Avenue****SEP 28 1943****William M. D.**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 26, 1943** **1: AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 1941** to **Sept. 26, 1943**, and that I last saw him alive on **Sept. 26, 1943**.

Immediate cause of death **Courtesy**
Thrombosis

Duration

12 hrs.Due to **mitral regurgitation****100-200-**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature **Frank L. DeBarren**

M. D.

Address **4723 Park Heights** Date signed **9-27-43**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

283099

G 08551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

526

G 08551
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EDWARD C. JAMISON

3 (b) If veteran, name war

3 (c) Social Security Account
No. 215-01-8491

4. Sex

MALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

ELIZABETH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-6-79

8. AGE: Years

64

Months

3

Days

20

If less than one day

hr

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name CHARLES JAMISON

13. Birthplace MD

14. Maiden Name ELLEN BERGUSON

15. Birthplace SCOTLAND

16 (a) Informant RECORDS

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal

(b) Date thereof

9/28/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 28 1943

V8 185

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

5312 Wendley Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1943, at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17-1943 to 9-26-1943, and that I last saw him alive on 19

Immediate cause of death PNEUMONIA

BLADDER TUMOR (URINARY)

Duration

2 yrs?

Due to

Due to

Other Conditions BLADDER TUMOR

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: SAME

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George H. Strong

Address J. H. H.

Date signed 9/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08552
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave

(c) Hospital or institution:

Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 71 years

3 (a) FULL NAME

Catherine Streebig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband

William Streebig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 4 - 1848

8. AGE: Years

94

Months

11

Days

23

If less than one day

hr.

min.

9. Birthplace

Germany

10. Usual Occupation

11. Industry or business

at home

12. Name

Wm Rausch

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant Freda Wigter(b) Address 782 W. Cross St17 (a) Basal (b) Date thereof 9/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory London ParkLocation Balto Md.18 (a) Funeral director William Cook Inc(b) Address 217 St. Paul St19 SEP 28 1943 (b) Huntington Williams, Md.

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 6000 Bellona Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 - 1943 12:40 PM21. I certify that death occurred on the date above stated, that I attended deceased from Dec 19 - 39 Sept 27 - 1943and that I last saw her alive on Sept 27 - 1943Immediate cause of death Gynous MyocarditisDue to Chronic NephritisOther Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) _____ While at work?

(e) Means of injury Chronic Nephritis23. Signature Wm RauschAddress 17 W. 25thDate Sept 27 - 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08553
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1412 Rosedale St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

3 (a) FULL NAME

Florence Lee Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Leighton Payne Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1865

8. AGE: Years 77 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Marshall Va.

10. Usual Occupation Housewife

11. Industry or business At Home

12. Name Dr. Harry Brown

13. Birthplace Va

14. Maiden Name Unknown

15. Birthplace Va

16 (a) Informant Stuart Brown

(b) Address Upper Marlboro Md.

17 (a) Burial (b) Date thereof 9/29/43

(c) Cemetery or crematory Joy Hill

Location Upperville Va.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) SEP 28 1943

Huntington Williams, Md.

VS 148

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1412 Rosedale St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27th 1943 at 4^{PM}

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943 to Sept 27 1943, and that I last saw him alive on Sept 26 1943.

Immediate cause of death

Arteriosclerosis
Ch. Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Walter J. Scynell

Address 1729 W. Lombard St Date signed 9/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08554

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address W. Fayette Street

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days

(e) Length of stay in Baltimore (yrs., mos., or days) none

3 (a) FULL NAME

Charles M. Engelmeier

(Charles M. Engelmeier)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Dora Deise

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 1st, 1873

8. AGE:

Years

Months

Days

If less than one day

69

11

25

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

Tailor

11. Industry or business Own business

12. Name Wolfgang Engelmeier

13. Birthplace Germany

14. Maiden Name Clara Wernig

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Dora Engelmeier (Wife)

(b) Address 1040 Alsquth Street

17 (a) Burial

(b) Date thereof Sept. 28, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd. Balto., Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a)

SEP 28 1943

William M. R.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County City

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1040 Alsquth Street

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/26/1943, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/1943 to 9/26/1943 and that I last saw him alive on 9/26/1943.

Immediate cause of death

Coronary Artery Thrombosis

Duration

2 weeks

Due to Myocardial infarction

Due to Arteriosclerosis

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Richard S. Ruth

M. D.

Address Bon Secours Hosp Date signed 9/26/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d G 08555
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

665 W Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Katherine J. Olmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 29, 1880

8. AGE:

Years

Months

Days

If less than one day

62 63

8

28

hr

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

at home

12. Name

Joseph J. Olmer

13. Birthplace

Germany

14. Maiden Name

Regina Kroll

15. Birthplace

Germany

16 (a) Informant

Mrs. Elizabeth T. Olmer

(b) Address

665 W Pratt St

17 (a)

Burial

(b) Date thereof

9/29/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cem.

Location

4300 Redwood Road

18 (a) Funeral director

Bluff & Sons

(b) Address

900 E. Hollins St

19 (a)

(b)

SEP 28 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) City or town

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

665 W Pratt St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 26, 1943 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943, to Sept 26 1943, and that I last saw him alive on Sept 25 1943.

Immediate cause of death

Chronic Myocarditis
Tonsillar Abscess

Duration

5 days

Due to

Due to

Other Conditions The Roulourenx

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Albert Scagnetti

Address 1729 W Lombard St

Date signed 9/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08556
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1011 Boyd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ORENE MIRACLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1942

8. AGE: Years Months Days If less than one day
1 4 16 7 hr. min.

9. Birthplace Lake City, Tenn.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Ovid Miracle

13. Birthplace Kentucky

14. Maiden Name Lorene E. Dix

15. Birthplace Tenn.

16 (a) Informant Mr. Ovid Miracle

(b) Address 1011 Boyd St

17 (a) burial (b) Date thereof 9/28/43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Reisterstown Ave.

18 (a) Funeral director John J. Corvan & Son

(b) Address 900 E. 3rd St. Hollins St.

19 (a) SEP 28 1943
(Date registered)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Boyd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1943, at 11:05 A. M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Broncho-pneumonia due to whooping cough.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wallenwater M.D.

Date signed Sept. 27, 1943 Medical Examiner.

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 03557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08557
137a Registered No.

PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>Calvert & Saratoga Sts</u> (c) Hospital or institution: <u>Mercy Hospital</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>22 days</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>3 yrs.</u>				2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md.</u> (b) County <u>Baltimore</u> (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>311 N. Mount St.</u> (If rural give location) (e) Citizen of foreign country? <u>No</u> (Yes or No) If yes, name country:			
3 (a) FULL NAME <u>Clarence Jerome Brown</u> 3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____							
4. Sex <u>M</u>		5. Color or race <u>Black</u>		6 (a) Single, married, widowed, or divorced <u>Widowed</u>			
6 (b) Name of husband or wife _____ 6 (c) If alive, give age _____ years							
7. Birth date of deceased (mo., day, yr.) <u>1890</u>							
8. AGE: Years <u>53</u>		Months _____		Days _____		If less than one day hr. _____ min. _____	
9. Birthplace <u>Balto. Co., Maryland</u> (Town, county, and state)							
10. Usual Occupation <u>Hardy man</u>							
11. Industry or business _____							
FATHER		12. Name <u>William Henry Brown</u>					
13. Birthplace <u>Balto. Co., Md.</u>		14. Maiden Name <u>Louphina Coleman</u>					
MOTHER		15. Birthplace <u>Lynchville, Md.</u>					
16 (a) Informant <u>Christina Brown</u>							
(b) Address <u>Cells Balto Co Md</u>							
17 (a) <u>Burial</u> (b) Date thereof <u>Sept 30-43</u> (Burial, cremation, or removal) (month) (day) (year)							
(c) Cemetery or crematorium <u>Balto Co</u> Location <u>Sam'l H. Chase Hom</u>							
18 (a) Funeral director <u>638-71 Gilmore St</u>							
(b) Address _____							
19 (a) _____ (b) _____ (Signed by registrar)							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Sept 26</u> 19 <u>43</u> at <u>10⁴⁵</u> P. M. 21. I certify that death occurred on the date above stated, that I attended deceased from <u>Sept 6</u> 19 <u>43</u> to <u>Sept 26</u> 19 <u>43</u> and that I last saw him alive on <u>Sept 26</u> 19 <u>43</u> . Immediate cause of death <u>Urethra</u> → Duration <u>22 days</u> Due to <u>urethral retention</u> <u>22 days</u> Due to <u>Prostatic hypertrophy</u> ? Other Conditions <u>Dental caries</u> <u>pyorrhea</u> <u>Cardiac hypertrophy</u> (Include pregnancy within 3 months of death) Date of operation <u>None</u> Major findings of operation: _____ of autopsy: _____ 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide _____ (b) Date of occurrence _____ at _____ M (c) Where did injury occur? _____ (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place) (e) Means of injury _____ 23. Signature <u>Thomas Brown</u> <u>Mercy Hospital</u> Date signed <u>9-26-43</u>							
PHYSICIAN Underline the cause to which death should be charged statistically.							

SEP 28 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08558

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6111 York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

GEORGE EMANUEL GERHOLD

3 (b) If veteran, name war
Sp. American

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Separated

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1878

8. AGE: Years Months Days If less than one day
65 8 17 hr. min.

9. Birthplace ? Germany

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business ?

12. Name Emanuel Gerhold

13. Birthplace Germany

14. Maiden Name Margaret Reymer

15. Birthplace Germany

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9/27/43
(Burial, cremation, or other disposal) (month) (day) (year)

(c) Cemetery or place of interment U.S. National
Location Balto. Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Sept. 26, 1943, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1943, to Sept. 26, 1943, and that I last saw him alive on Sept. 26, 1943.

Immediate cause of death 1-Occlusion left
main pulmonary artery; 2-Adeno
carcinoma of the prostate

Due to Thrombosis

Duration

1-9/26/43
2-Unk.

Other Conditions: Fracture 7/28/43
simple, femur right.

Date of operation-
8/2/43-Open reduction; 8/19-Trans-

(Include pregnancy within 3 months of death)

Date of operation: urethral prostatictomy

Major findings of operation: Smith-Peterson
nail inserted rt. femur; Benign
hyperplasia of prostate with
possible malignant changes
of autopsy - as above.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident, suicide

(b) Date of occurrence July 26-'43 at 7:28 A M

(c) Where did injury occur? 6111 York Road
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? Home While at work? No
(Specify type of place)

(e) Means of injury: Slipped or fell down stairs

23. Signature

Address Baltimore, Md. Date signed 9/27/43

Approved by Howard J. Mulder M.D.

SEP 28 1943
Huntington Williams

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

456 G 08559
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1445 Parrish St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Parrish
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME James Comeygo
3 (b) If veteran, name was
3 (c) Social Security Account No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Ella Comeygo
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years 81 Months Days If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Unknown 13. Birthplace Unknown
MOTHER 14. Maiden Name Unknown 15. Birthplace Unknown

16 (a) Informant Arthur Comeygo
(b) Address 1445 Parrish St.

17 (a) Burial (b) Date thereof 9/28/43
(c) Cemetery or crematory Mt Airy
Location Md

18 (a) Funeral director Des. H. Kelsay
(b) Address 1303 Pressman St.

19 (a) (b) H. H. Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1943 at 2:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1943 to Sept 28 1943, and that I last saw him alive on Sept 28 1943.
Immediate cause of death

Carcinoma of Tongue
Due to

Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:
22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature E. Williams M.D.
Address 928 Pa. Ave Date signed 9/27/43

Duration 8 months
PHYSICIAN
Underline the cause to which death should be charged statistically.

SEP 28 1943

For P.H.M. - Haller - approved by Howard J. Muller, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08560

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08560

160a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Paulwood + Green Sts.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Baltimore
(c) City or town: Baltimore
(d) Street No.: 1000 University Hospital
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME

Baby Boy Tangle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male white

5. Color or race

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-24-43

8. AGE:

Years

Months

Days

If less than one day

3

hr.

min.

9. Birthplace

University Hospital
Paulwood + Green Sts.

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Richard Wilson Tangle

13. Birthplace

Solomons Island, Md

14. Maiden Name

Elizabeth Tangle

15. Birthplace

St. Mary's County, Md.

16 (a) Informant

Elizabeth Tangle

(b) Address

1000 N. Towson St.

17 (a) burial

(b) Date thereof 9/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

4300 Old Federal Rd.

18 (a) Funeral director

John J. Brownson

(b) Address

901 Hollins St.

19 (a)

(b)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1943 at 12:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1943 to 9-27 1943 and that I last saw him alive on 9-27-43

Immediate cause of death

Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Raymond B. Bangle

Address

University Hospital

Date signed 9-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 08561	
CERTIFICATE OF DEATH		93d Registered No.	
1. PLACE OF DEATH:			
(a) Baltimore City, Maryland			
(b) Street address <u>Green Spring & Belvedere</u>			
(c) Hospital or institution: <u>Hebrew Home for Aged & Infirm</u>			
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>7 yrs.</u>			
(e) Length of stay in Baltimore (yrs., mos., or days)			
2. USUAL RESIDENCE OF DECEASED:			
(a) State <u>md</u> (b) County			
(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)			
(d) Street No. <u>Green Spring & Belvedere</u> (If rural give location)			
(e) Citizen of foreign country? (Yes or No) If yes, name country			
3 (a) FULL NAME <u>Fannie Rosen</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6 (a) Single, married, <u>widowed</u> , or divorced	
6 (b) Name of husband or wife <u>Meyer Rosen</u>		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>1876</u>			
8. AGE: Years <u>67</u>	Months	Days	If less than one day hr. min.
9. Birthplace <u>Poland</u> (Town, county, and state)			
10. Usual Occupation <u>Nursewife</u>			
11. Industry or business			
12. Name <u>Poland</u>			
13. Birthplace <u>Poland</u>			
14. Maiden Name <u>Poland</u>			
15. Birthplace <u>Poland</u>			
16 (a) Informant <u>Bernard Rosen</u>			
(b) Address <u>4508 Lenox Ave</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>9-28-43</u> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Hebrew Int. Cemetery</u> Location			
18 (a) Funeral director <u>Joseph Weiss Inc</u>			
(b) Address <u>1439 E. Balt. St</u>			
19 <u>SEP 26 1943</u> (b) <u>Huntington Williams, M.D.</u> Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Sept. 27, 1943</u> at <u>4¹⁵ P.M.</u>			
21. I certify that death occurred on the date above stated; that I attended deceased from <u>3-18/1936</u> to <u>9-27-1943</u> , and that I last saw <u>her</u> alive on <u>9-27-1943</u> .			
Immediate cause of death <u>Ch. card. vascular disease</u> <u>Hypertension, Arteriosclerosis</u>			Duration
Due to			
Due to			
Other Conditions			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(e) Means of injury			
23. Signature <u>Edmund L. Levin</u>			
Address <u>Levendale</u>			Date signed <u>9/28/43</u>

297698

G 08562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08562

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Agnes Bethke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Robert Bethke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-27-71

8. AGE:

Years

Months

Days

If less than one day

72

4

0

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

12. Name

Charles Hare

13. Birthplace

Germany

14. Maiden Name

Ernestine ?

15. Birthplace

Germany

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

Sep 30 43

(c) Cemetery or crematory

Zion Lutheran

Location

Balt. Co. Md

18 (a) Funeral director

Lassell Funeral Home

(b) Address

7401 Belvoir Rd

19 (a)

(Date of registration)

SEP 28 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore Co.

(c) City or town

Rosedale

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7919 Shirley Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27 1943

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1943 to Sept 27 1943, and that I last saw her alive on Sept 27 1943.

Immediate cause of death

Cerebral aneurysm

Duration

Due to

Myocardial infarct

Due to

Cerebral aneurysm

Other Conditions

Fractured femur

(Include pregnancy within 3 months of death)

Date of operation

8-2-43

Major findings of operation:

Fracture of femur

or autopsy:

Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Accident

(b) Date of occurrence

8-2-43

at 5:15 PM

(c) Where did injury occur?

Baltimore

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? No

(e) Means of injury

Fall

Signature

George Bunch Jr.

Address

Johns Hopkins HOSP.

Date signed

9-27-43

Approved by Thomas J. McManis, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08563

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

1192 G 08563
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga Sts*

(c) Hospital or institution:

Mary Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 1/2 days*

3 (a) FULL NAME

Barbara Howe Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/3/43

8. AGE: Years Months Days If less than one day

*0**0**24*

hr.

min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER

12. Name *Arthur Whitney Fletcher*13. Birthplace *Balto., Md.*

MOTHER

14. Maiden Name *Carolyn Creekhan*15. Birthplace *Balto., Md.*16 (a) Informant *Dr. Arthur Fletcher*(b) Address *2304 Lyndhurst Ave*17 (a) *Exemption* (b) Date thereof *Sept 28/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Fort Lincoln*Location *Maryland*18 (a) Funeral director *Harry H. Witzke*(b) Address *4101 Edmondson Ave.*19 (a) (b) *Huntington Williams**SEP 28 1943*

VS 119

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Balto.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2304 Lyndhurst Ave*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 26, 1943* at *7 P M*21. I certify that death occurred on the date above stated; that I attended deceased from *9/22 1943* to *9/26 1943* and that I last saw her alive on *9/26 1943*.Immediate cause of death *Cardio-Respiratory Failure*Due to *Neonatal Diabetes* *24 days*Due to *Shock*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Robert B. Turner* Date signed *9/26/43*Address *Mary Hosp.*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 1/2 TREMONT ROAD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 1/2 TREMONT ROAD
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME BESSIE MAE NORMAN
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-16-0865

4. Sex FEMALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced WIDOWED
6 (b) Name of husband or wife WILLIAM ELDRIDGE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG-24-1879
8. AGE: Years 64 Months 1 Days 3 If less than one day hr. min.

9. Birthplace HOWARD Co.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

12. Name ELIAS BUCKINGHAM
13. Birthplace CARROLL Co.
14. Maiden Name ALICE RECORD
15. Birthplace CARROLL Co.

16 (a) Informant MRS. HOWARD BUCKINGHAM
(b) Address 116 1/2 TREMONT ROAD.

17 (a) BURIAL (b) Date thereof SEPT 30-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LONDON PARK
Location FREDERICK AVE.

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 LEEDS AVENUE.
65P 28 1943 (b) Huntington Williams, M.D.
(Disseminated by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1943, at 2:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1940, to 9-27 1943, and that I last saw her alive on 9-27 1943.

Immediate cause of death
Intracranial Hemorrhage
Due to Arterial Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Alvin H. Greenlee
Address 4209 Ind. Ave Date signed 9-27-43 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematorium

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1943, to Sept 26 1943, and that I last saw him alive on Sept 20 1943.

Immediate cause of death

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08566
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
South Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 E. Fort Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ALICE L. DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 15, 1938

8. AGE:

Years

Months

Days

If less than one day

5

2

11

hr.

min.

9. Birthplace

Baers

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Charles Davis

13. Birthplace

Ind.

14. Maiden Name

Sarah M. Harrison

15. Birthplace

Ind.

16 (a) Informant

Family

(b) Address

134 E. Fort Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

9-28-43

(c) Cemetery or crematory

Lawson Park

Location

Frederick Ave.

18 (a) Funeral director

James L. Buckley

(b) Address

134 E. Fort Ave.

SEP 28 1943
(Date filed by registrar)

(b)

Harrison Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1943 at 11:50 A.

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒, accident ☐, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia lobular.

Due to Cause undetermined.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury _____

23. Signature W. J. Williams M.D.

Date signed Sept. 27, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20 1866 Fulton St. 08567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3345 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3345 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cosimo Matassa
3 (b) If veteran, name war 3 (c) Social Security Account No.
4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Teresa Di Pietro 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 27, 1872
8. AGE: Years 71 Months - Days 28 If less than one day hr. min.
9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired Shoe maker
11. Industry or business Business for self
12. Name Pasquale Matassa
13. Birthplace Italy
14. Maiden Name Josephine Fortitta
15. Birthplace Italy
16 (a) Informant Wife
(b) Address 3345 Belair Road
17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Frank V. Pipitone
(b) Address 2418 E. Balto St
19 (a) SEP 28 1943 (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept 25 1943. at 3:00 am
21. I certify that death occurred on the date above stated; that I attended deceased from April 1943 to Sept 1943, and that I last saw him alive on Sept 19 1943
Immediate cause of death Coronary Thrombosis
Due to Cardiac Vascular Hypertensive Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. H. Harman
Address 436 E. Pratt Ave Date signed 9/27/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 08568

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Redwood + Green St.

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Cornelia Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Sidney Freeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 1888

8. AGE:

Years

Months

Days

55

6

If less than one day

hr.

min.

9. Birthplace Hope Co. Md.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name

Lewis McNeal

13. Birthplace

Hope Co. Md.

14. Maiden Name

15. Birthplace

16 (a) Informant Sidney Freeman

(b) Address 215 + Myrtle Ave

17 (a) Burial

(b) Date thereof Sept. 29, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem

Location

18 (a) Funeral director

Mrs. Katel R. Williams

(b) Address

322 N. Lakeside St

19 (a)

(b)

SEP 28 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Balto.

(d) Street No.

215 Myrtle Ave

(e) Citizen of foreign country?

(If rural give location)

(f) If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-25

1943, 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1943, to 9-25 1943, and that I last saw him alive on 9-25 1943.

Immediate cause of death

Respiratory Failure

Due to Acute Pulmonary Edema

Due to

Other Conditions

Dehydration; Multiple Abrasions.

(Include pregnancy within 1 month of death)

Date of operation 9-25-43

Major findings of operations: Brain edema; 9 abrasions; 10 respiratory.

of autopsy: Pulmonary edema; Furunculosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

(Specify type of place)

(f) While at work?

(g) Signature

Address

University Hospital

Date signed

SEP 28 1943

Huntington Williams, M.D.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH *Volunteers of Amer. Hosp.* *161a*
 CITY OF BALTIMORE: (No. *418 W. Lexington*) St. *1* Ward

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. *1* mo. *1* da. How long in U. S. If of foreign birth? yrs. *1* mo. *1* da.2. FULL NAME *William Allen Wolf*

If U. S. Veteran—

specify WAR _____

(a) Residence: No. *2000 Penrose Ave* St. *1* Ward

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. Color or Race *W* 5. Single, Married, Widowed, or Divorced (write the word) *Single*6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day, year) *Sept 27, 1943*7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, *5* hrs. or *12* min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) *Balto*
(State or country) *Me*13. NAME *Allen Wolf*14. BIRTHPLACE (city or town) *Balto*
(State or country) *Me*15. MAIDEN NAME *Noreen McLooney*16. BIRTHPLACE (city or town) *Balto*
(State or country) *Me*17. INFORMANT *Noreen Wolf*
(Address) *2000 Penrose Ave*

18. BURIAL, CREMATION, OR REMOVAL

Place *St Marys Hospital* Date *Sept 28 1943*19. UNDERTAKER *Cheney & Co*
(Address) *2018 Lexington Ave*

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *Sept. 27, 1943*22. I HEREBY CERTIFY, That I attended deceased from *Sept 27* 19*43* to *Sept 27* 19*43*I last saw him alive on *Sept 27* 19*43* Death is said to have occurred on the date stated above, at *2:30 p.m.*

The principal cause of death and related causes of importance were as follows:

Respiratory failure
Congenital Atrial Septal Defect

Date of onset

*9/27/43**9/27/43*

Other contributory causes of importance:

Was an operation performed? _____ Date of _____

For what disease or injury? _____

Name of operation _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *Leonard Zapp* M. D.(Address) *Voluntary America Hosp*

SEP 28 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08570
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4207 Valley View Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Valley View Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Florence V. Howard

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 26, 1880

8. AGE:

Years

Months

Days

If less than one day

62

9

1

hr.

min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

William E. Van Rossum

13. Birthplace

Baltimore Md.

14. Maiden Name

Kate Plumber

15. Birthplace

Baltimore Md.

16 (a) Informant

Florence Howard

(b) Address

4207 Valley View Ave

17 (a)

Burial

(b) Date thereof

9/29/43
(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Taylor Ave

18 (a) Funeral director

Howard H. Blight

(b) Address

4914 Belair Road

SEP 28 1943

Huntington Williams, M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/27

1943, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1943, to 9/27 1943 and that I last saw him alive on 9/21 1943.

Immediate cause of death

Chronic Myocarditis

Duration

unknown

Due to

Due to

Other Conditions

Malnutrition

Secondary Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John A. Macken

Address

630 x Belair Rd

Date signed 9/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a G 08571
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1 life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Boston
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN FRALEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Antonya Fraley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1890

8. AGE: Years 53 Months 11 Days 11 hr. min.

9. Birthplace Balto., Maryland.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name John Fraley

13. Birthplace Bohemia

14. Maiden Name Elizabeth Brannan

15. Birthplace Bohemia

16 (a) Informant Mrs. Rozanek

(b) Address 2306 Boston St

17 (a) Burial (b) Date thereof Sept 19, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemers

Location Baltimore

18 (a) Funeral director Fred W. Gajewski

(b) Address 1930 Eastern Ave

19 (a) (Date and place of registration) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1943 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1943 to 9/26 1943, and that I last saw him alive on 9/26 1943

Immediate cause of death

Coronary Occlusion 6 hrs.

Due to Preexisting

Due to attacks of

Other Conditions coronary occlusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles R. McDermott

Address 1213 Light St Date signed 9/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Approved by Howard J. Malachuk, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 08572

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-43.

8. AGE: Years Months Days If less than one day
1 33 2 hr. min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Ernest Cooper

13. Birthplace

Balto, Md.

14. Maiden Name

Eurendolyn Hayward

15. Birthplace

Balto, Md.

16 (a) Informant

Edgar Hayward

(b) Address

2241 Madison Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof Sept. 25, 1943

(c) Cemetery or crematorium

Providence Hospital

Location

Baltimore Co. Md.

18 (a) Funeral director

Mr. George H. Halland

(b) Address

1631 W. 1st St. Ave.

SEP 28 1943

VB 150

Huntington Halliday, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

2241 Madison Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27 1943, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1943, to Sept 27 1943, and that I last saw him alive on Sept 27 1943.

Immediate cause of death

Acute Gastroenteritis

Duration

Due to

Due to

Other Conditions

Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edgar Hayward

Address

Providence Hospital

Date signed

M. D.

08573

G 08573

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

If U. S. Veteran
specify WAR...

(a) Residence: No. 1120 N. Carey

(a) Residence: No. 1100 N. Carey St., _____ Ward, _____
(Usual place of abode) (If non-resident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

11. DATE OF DEATH (month, day, year) Refo. 26 1983

23. I HEREBY CERTIFY, That I attended deceased from
 Rep. 21 to 43 to Rep. 26 - 1947

I last saw h. a. alive on Apr. 26, 1943. Death is said to have occurred on the date stated above, at 6:40 a.m.

The principal cause of death and related causes of importance were as follows:

DATE:

Phonice Myo caudatus

Other contributory causes of importance:

Old age

Was an operation performed? _____ Date of _____

For what disease or injury?

Name of operation

What test confirmed diagnosis? Chlamydia Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

(State of country) *Sp. Italy - 6a Mo*

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury	
------------------	--

Nature of injury	
------------------	--

24. Was disease or injury in any way related to occupation of deceased?

If so, specify find & treat

(Signed) Edward J. Heaney M. D.

(Address) 1240 N. 1st St. N. W.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08574

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08574
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BRADY AMY POEHLMAN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or
divorced Married

6 (b) Name of husband or wife
Geo W. F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29-1911

8. AGE: Years Months Days If less than one day
32 4 27 18 hr. min.

9. Birthplace
Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
Housework

11. Industry or business

12. Name
Melvin F. Jones

13. Birthplace
Dorchester Co., Md.

14. Maiden Name
Amy Jones

15. Birthplace
Dorchester Co., Md.

16 (a) Informant
Reta Bramble

(b) Address
7526 Harford Rd.

17 (a) Burial (b) Date thereof Sept 30-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or burying place
London Park

Location
Frederick Rd.

18 (a) Funeral director
John A. Johnson

(b) Address
3010 E. Baltimore St.

19 (a) SEP 28 1943
(Date and by whom signed) (Signature) (Name)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1943, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carbon Monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 9-27-43 at A. M.

(b) Where did injury occur? at home address

(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work?

(d) Means of injury Kitchen gas jets

23. Signature H. W. Williams M.D.
Medical Examiner.

Date signed Sept. 27, 1943

G 08575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08575

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5932 Greenhill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 16

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 11 - 1943

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name

James T. Insley Jr. MD.

13. Birthplace

Baltimore

14. Maiden Name

Catherine Elizabeth Walker

15. Birthplace

Baltimore

16 (a) Informant

James T. Insley Jr.

(b) Address

2936 E. Baltimore St.

17 (a)

Burial

(b) Date thereof Sept. 29 - 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

Funderburg Rd.

18 (a) Funeral director

John A. McLean

(b) Address

3977 E. Baltimore St.

19 (a)

(Date rec'd by registrar)

SEP 28 1943

(b) Funeral home

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5932 Greenhill Ave.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 27, 1943 at 12:11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1943 to Sept 27 1943, and that I last saw him alive on Sept 26 1943

Immediate cause of death

Cardiac failure

Due to

Tetralogy of Fallot

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

James T. Insley Jr.

Address

2936 E. Baltimore St.

Date signed

9/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08576

Registered No.

83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

203 E Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

203 E Lafayette St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

JAMES MILLAR

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. 090-05-8136

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 4, 1882

8. AGE:

Years

Months

Days

If less than one day

61

7

2324

hr.

min.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual Occupation

Pipe Coverer

11. Industry or business

Bethlehem Shipyard

12. Name

William Miller

13. Birthplace

Scotland

14. Maiden Name

Christine Ritchey

15. Birthplace

Scotland

16 (a) Informant

Mrs Agnes Miller

(b) Address

203 E Lafayette St

17 (a) Removal (Burial, cremation, or removal)

Removal

(b) Date thereon (month) (day) (year)

Sept. 27, 1943

(c) Cemetery or crematory

Woodlawn

Location

New York City

18 (a) Funeral director

William Cook, Inc

(b) Address

1217 St Paul St

SEP 28 1943

(b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 28, 1943, at 4:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26, 1943, to Sept. 27, 1943, and that I last saw him alive on Sept. 27, 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

2 Days

Due to

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Conrad Bode

M. D.

Address

Date signed

Sept 28/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 08577	
CERTIFICATE OF DEATH		119a Registered No.	
1. PLACE OF DEATH:			
(a) Baltimore City, Maryland			
(b) Street address 840 W. Baltimore St.			
(c) Hospital or institution:			
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18			
(e) Length of stay in Baltimore (yrs., mos., or days)			
2. USUAL RESIDENCE OF DECEASED:			
(a) State Md. (b) County			
(c) City or town Baltimore			
(d) Street No. 840 W. Baltimore St.			
(e) Citizen of foreign country? (If rural give location) (Yes or No)			
3 (a) FULL NAME DEWEY WALLACE			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex Male	5. Color or race White	6 (a) Single, married, widowed, or divorced Single	
6 (b) Name of husband or wife			
6 (c) If alive, give age — years			
7. Birth date of deceased (mo., day, yr.) July 22, 1943			
8. AGE: Years	Months	Days	If less than one day
	2	6	hr. min.
9. Birthplace Cleveland, Tennessee			
(Town, county, and state)			
10. Usual Occupation			
11. Industry or business			
12. Name Dewey Wallace			
13. Birthplace Cleveland, Tenn.			
14. Maiden Name Mary Brown			
15. Birthplace Tennessee			
16 (a) Informant Mr. Dewey Wallace			
(b) Address 840 W. Baltimore St.			
17 (a) burial (b) Date thereof 9/20/43			
(Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory Charleston, Tenn.			
Location Charleston, Tennessee			
18 (a) Funeral director John J. Cowan & Son			
(b) Address 901 E. 3rd St.			
19 SEP 28 1943			
Huntington Williams, M.D. Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH September 28, 1943, at M			
21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> and that the cause of death were: Immediate Cause of Death Acute Bronchitis			
Due to			
Other Conditions			
(Include pregnancy within 3 months of death)			
22. If an external cause was primary <input type="checkbox"/> or contributing <input type="checkbox"/> cause of death, fill in the following:			
(a) Date of injury at M.			
(b) Where did injury occur?			
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?			
(d) Means of injury			
23. Signature Homer J. Walden M.D.			
Date signed 9-28-43 Medical Examiner.			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08578

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 129 E. West St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 129 E. West St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Barbara E. Meyd

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

FEMALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 9 - 1858

8. AGE: Years Months Days

85

8

17

If less than one day

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Own Home

12. Name Leonard Meyd

13. Birthplace Germany

14. Maiden Name Magdelene Kaufman

15. Birthplace Germany

16 (a) Informant Miss Katherine Meyd

(b) Address 129 E. West St.

17 (a) Burial (b) Date thereof Sept. 29 - 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel Co.

18 (a) Funeral director Elizabeth A. Clark Inc.

(b) Address 115 E. West St.

SEP 28 1943

Registrar William H. R.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943 at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1943 to Sept 26 1943 and that I last saw her live on Sept 25 1943.

Immediate cause of death

Myocardial Insufficiency

Due to

Due to

Other conditions Arteriosclerosis, Hypertension, Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature John C. Schenck

Address 1337 S. Charles St. Date signed 9/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

20 (b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 6:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 6, 1943 to Sept 28, 1943, and that I last saw him alive on Sept 26, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 28 1943

VS 150

CHAS. R. MAREK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 8580

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2209 Prentiss Place

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE ON DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2209 Prentiss Place

(If rural give location)

(e) Citizen of foreign country?

No (Yes or No)

3 (a) FULL NAME

Anton Pokorny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5 Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Photo finisher

11. Industry or business

FATHER

12. Name

Anton Pokorny

13. Birthplace

Bohemia

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Bohemia

16 (a) Informant

Joseph Pokorny

(b) Address

2209 Prentiss Place

17 (a) Burial

(b) Date thereof 9-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md

18 (a) Funeral director

Frank Brockway

(b) Address

900 N. Chester St

19 (a) Date of death

Sept 28 1943

(b) Registrar

H. H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943 at 10:20 AM

21. I certify that death occurred on the date above stated that I attended deceased from Aug 17 1943 to Sept 26 1943 and that I last saw him alive on July 3 1943

Immediate cause of death

Chr. Valvular Heart Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Vincent J. Jocka

Address

845 N. Patterson St

Date signed 9/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08581
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 700 N 40th St.
(c) Hospital or institution: The Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N 40th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3 (a) FULL NAME

Miss Kate Cooper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4, 1858

8. AGE: Years 84 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Miss Clerk

11. Industry or business Post Office Dept

12. Name Samuel Cooper

13. Birthplace Dublin, Ireland

14. Maiden Name Charlotte Anne Willing

15. Birthplace Baltimore, Md.

16 (a) Informant Miss J. Frankfield

(b) Address 108 N. Duquesne Ave.

17 (a) Burial (b) Date thereof Sept. 29, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Cemetery

Location Baltimore, Md.

18 (a) Funeral director Miss Lamon

(b) Address 4510 Liberty Hgts. Ave.

19 SEP 28 1943 (b) Registrar

20. DATE OF DEATH Sept 27 1943 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1938, to 9/26 1943, and that I last saw him alive on 9/26 1943.

Immediate cause of death Coronary Failure

Due to Arteriosclerosis (gen + coronary) 10 yrs

Due to Hypertension (essential) 12 yrs

Other Conditions Fracture R 1st rib 15 yrs

(Include pregnancy within 9 months of death)

Date of operation
Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Grafton Hargraves

Address 21 E. Michigan St. Del. Date signed 9/26/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 3
H. Grafton Hargraves, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 08582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08582
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Dumbarton Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME

John James Opdyke

3 (b) If veteran, name war

3 (c) Social Security Account
No. —

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1943

8. AGE: Years Months Days If less than one day
0 0 21 — hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Mr. Orris J. Opdyke Jr.

13. Birthplace Maryland

14. Maiden Name Mary M. Adams

15. Birthplace Maryland

16 (a) Informant History

(b) Address

17 (a) Burial (b) Date thereof Sept. 30, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Samuel M. Bussis

(b) Address Sparks, Md.

SEP 28 1943 (b) Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1943 at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1943 to Sept. 28 1943 and that I last saw him alive on Sept. 28 1943.

Immediate cause of death Cardio-respiratory failure

Due to pyloric stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Sept. 28, 1943

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George L. Murtagh Jr. M. D.

Address 332 E. University Pkwy Date signed 9-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

03583

58583
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Zelda Amdur

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

Female

White

Widow

6 (b) Name of husband or wife

Late Carl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1861

8. AGE: Years

Months

Days

If less than one day

82

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

None

FATHER

12. Name

Unkown

13. Birthplace

Russia

MOTHER

14. Maiden Name

Unkown

15. Birthplace

Russia

16 (a) Informant

Samuel Amdur

(b) Address

4308 Pimlico Road

17 (a) Burial

(b) Date thereof Sept. 29, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Rosedale Cem

Location

Hamilton Ave

18 (a) Funeral director

Sol Levinson & Bros

(b) Address

1124 1126 W North Ave

SEP 29 1943

VS 150

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

4.30

20. DATE OF DEATH Sept 28, 1943, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1943, to Sep. 27, 1943, and that I last saw him alive on Sep. 27, 1943.

Immediate cause of death

Duration

Acute cardiac failure 1 day

Due to

Anterior infarction

Due to

hypertension heart

59

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Huntington Williams

240 E. Calver

9/28/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08584

1. PLACE OF DEATH:
Baltimore City, Maryland
Baltimore, Md.
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
WALTER D. BOOKER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1928

8. AGE: Years 20 Months 3 Days 11
If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name Daniel Booker
13. Birthplace Pa
14. Maiden Name Sarah Brown
15. Birthplace Md

16 (a) Informant Daniel Booker
(b) Address 1042 Edmondson

17 (a) Burial (b) Date thereof Sept 30-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ashbury M.E.
Location

18 (a) Funeral director Sam W. Chase & Son
(b) Address 638 N. Gilman St.

SEP 29 1943 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1943 12:10 A.
19 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-26-43 at 6:50 P. M.

(b) Where did injury occur 617 Dolphin St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No

(d) Means of injury Stab wound of chest. - altercation

23. Signature H. W. Williams M.D.

Date signed 9-27-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

0585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08585

Registered No.

83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 925 N. Calvert St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 925 N. Calvert St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Annie T. Bishop

3 (b) If veteran, name war

3 (c) Social Security Account

None

No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband Ungil Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Dec. 17th 1883

8. AGE: Years 59 Months 9 Days 10th If less than one day hr. min.

9. Birthplace St. Louis Mo.

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

12. Name Peter Cooper Gubernovich

13. Birthplace Swiss

14. Maiden Name Josephine C. Lotz

15. Birthplace New Orleans La.

16 (a) Informant Mr. Fayne C. Carner

(b) Address 925 N. Calvert St

17 (a) Removal (b) Date thereof 9/29/43

(Reason, removal, or removal) (month) (day) (year)

(c) Cemetery or burying place Cedar Hill

Location Decatur Ala.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St. Paul St.

19 SEP 29 1943

(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28th 1943 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Sept 28 1943 and that I last saw him alive on Sept 27 1943

Immediate cause of death

Terminal pneumonia Duration 2 days

Due to Cerebral hemorrhage 4 days

Due to Arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm Cook Inc

Address 116 E. Eager St Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 109572
G 03586

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 29 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1943 at 9⁰⁰ M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1943 to Sept. 27 1943, and that I last saw him alive on Sept. 27 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Bronchopneumonia

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. Arthur Rossberg M.D.

Address St. Agnes Hosp. Date signed 9/27/43

08587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08587

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 613 E. 36th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Bertha E. King

3 (b) If veteran, name war

W

3 (c) Social Security Account

No.

FIVE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, year) Aug 21st 1872

8. AGE:

Years

Months

Days

If less than one day

71

1

6

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

Self

12. Name

Samuel R. King

13. Birthplace

Md.

14. Maiden Name

Margaret Warner

15. Birthplace

Md.

16 (a) Informant

Harry W. King

16 (b) Address

613 E. 36th St

17 (a)

Burial

(b) Date thereof

9/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Mount

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

SEP 29 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

613 E. 36th St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27th 1943 at 4:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 11th 1943 to 27th 1943, and that I last saw him alive on 27th 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. P. Stuebler

Address

632 French Ave

Date signed

M. D.

10/1/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 08588

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Alfred Harvey

3 (b) If veteran, name war

NI

3 (c) Social Security Account

No.

118E

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Clara A. Harveys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) 17-1864

8. AGE: Years Months Days If less than one day

19

3

11

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

Self

12. Name

Alfred Harvey

13. Birthplace

Balto Md.

14. Maiden Name

Margaret (Unknown)

15. Birthplace

Balto Md.

16 (a) Informant Margaret D. Bayne

(b) Address 1519 W. Retreat St.

17 (a) Burial (b) Date thereof 10/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery Woodland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) SEP 29 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town 1519 Retreat St. - Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1943 at 12 Noon

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Waldeis M.D.

Date signed 9-28-43

Medical Examiner.

08589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08589
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert St.*

(c) Hospital or institution:

Mercy Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*(e) Length of stay in Baltimore (yrs., mos., or days) *2 days*

3 (a) FULL NAME

David Bruce Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/7/43

8. AGE: Years

Months

Days

If less than one day

20

hr.

min.

9. Birthplace *Balto.*

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER12. Name *Clarence Buck*13. Birthplace *CLARKSBURG W. VA.*14. Maiden Name *Joan Schmiedich*15. Birthplace *Balto.*16 (a) Informant *Mother*(b) Address *1833 PORTSHIP RD.*17 (a) *Burial*(b) Date thereof *Sept 29/43*

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address *2024 Calver Ave*

18 (b) Address

18 (c) Address

18 (d) Address

18 (e) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

Baltimore

(c) City or town

Balto. Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1833 PORTSHIP RD

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 29 1943 at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *9/28 1943* to *9/27 1943* and that I last saw him alive on *9/27 1943*

Immediate cause of death

*Cardio-Respiratory Failure*Due to *Neo-natal asphyxia*Due to *Pneumonia*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature *A. E. Ineen*Address *Mary Hop* Date signed *9/27/43*

Duration

*9 days**1 day*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

SEP 29 1943

VB 124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08590 F.N. 83880		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		G 08590 Registered No.	
1. PLACE OF DEATH:			2. USUAL RESIDENCE OF DECEASED:		
(a) Baltimore City, Maryland			(a) State <u>Maryland</u> (b) County		
(b) Street address <u>4940 Eastern Ave</u>			(c) City or town <u>Baltimore</u>		
(c) Hospital or institution: <u>Baltimore City Hospitals</u>			(d) Street No. <u>408 S. Vincent St</u> (If outside city or town limits, write RURAL and give town)		
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>10 days</u>			(e) Citizen of foreign country? (If rural give location)		
(e) Length of stay in Baltimore (yrs., mos., or days)			(f) If yes, name country (Yes or No)		
3 (a) FULL NAME <u>Edward Carrick</u>					
3 (b) If veteran, name war			3 (c) Social Security Account No.		
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>Married</u>			
6 (b) Name of husband or wife <u>Ada</u>					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) <u>Mar 10, 1883</u>					
8. AGE: Years <u>60</u>	Months <u>6</u>	Days <u>18</u>	If less than one day hr. min.		
9. Birthplace <u>Maryland</u> (Town, county, and state)					
10. Usual Occupation					
11. Industry or business					
12. Name <u>Benjamin Carrick</u>					
13. Birthplace <u>Maryland</u>					
14. Maiden Name <u>Nettie Keene</u>					
15. Birthplace <u>Maryland</u>					
16 (a) Informant <u>Baltimore City Hospitals</u>					
(b) Address <u>4940 Eastern Ave (Records)</u>					
17 (a) (b) Date thereof <u>10/2/43</u> (Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory <u>Loufow Park</u> Location <u>Fernwood</u>					
18 (a) Funeral director <u>A. Jones</u>					
(b) Address <u>111 S. Guilford St</u>					
19 (a) <u>SEP-20-1943</u> <u>Huntington Williams</u>					
20. MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>9/25</u> 19 <u>43</u> at <u>3:38</u> A.M.					
21. I certify that death occurred on the date above stated; that I attended deceased from <u>9/1/43</u> to <u>9/25</u> 19 <u>43</u> , and that I last saw him alive on <u>9/25</u> 19 <u>43</u> .					
Immediate cause of death <u>Cerebral thrombosis or hemorrhage?</u>					
Due to <u>H.C.V. disease</u>					
Due to					
Other Conditions <u>old hemiplegia; many had infection</u> (Include pregnancy within 3 months of death)					
Date of operation					
Major findings of operations					
of autopsy: <u>no post</u>					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at M					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? <u>While at work?</u> (Specify type of place)					
(e) Means of injury					
23. Signature <u>E. L. Seigman</u>					
Address <u>BCH</u> Date signed <u>9/25</u>					

G 08591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08591
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 806 S. Broadway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217 14 9127

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 20 1881

8. AGE:

Years

Months

Days

If less than one day

6205

hr.

min.

9. Birthplace RUSSIA

(Town, county, and state)

10. Usual Occupation SEAMAN

11. Industry or business

FATHER
MOTHER12. Name UNKNOWN13. Birthplace UNKNOWN14. Maiden Name UNKNOWN15. Birthplace UNKNOWN16 (a) Informant PASSPORT RECORDS

(b) Address

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof SEPT. 29/43

(month) (day) (year)

(c) Cemetery or crematory ST. MATTHEWLocation ODONNELL ST.18 (a) Funeral director Lilly and Geiler INC.(b) Address 403 S. WOLFE ST.19 (a) SEP 29 1943

(Date signed by)

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1943, at 1 P M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept. 25 1943 1 P M.(b) Where did injury occur? 806 S. Broadway(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No(d) Means of injury Hanged self with sheet23. Signature Robert Lee Graham M.D.Date signed Sept 26 1943 Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08592

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name and

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP-29-1942

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from to and that I last saw alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed

G 08593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 08593
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2142 Hallins St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Elizabeth Louise Kelly

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-3-1863

8. AGE:

Years

Months

Days

If less than one day

80

4

24

hr.

min.

9. Birthplace

Balls Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Vincent Hayman

13. Birthplace

Germany

14. Maiden Name

Barba Lerner

15. Birthplace

Germany

16 (a) Informant

H. Thomas Kelly

(b) Address

2142 Hallins St

17 (a)

Burial

(b) Date thereof

9-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Frederick Rd.

18 (a) Funeral director

Edward Taylor

(b) Address

259 Wash Blvd

19 (a)

(b)

H. Thomas Kelly

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto city

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2142 Hallins St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1943, at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1943, to Sept. 27 1943, and that I last saw her alive on Sept. 26 1943.

Immediate cause of death

Hypostatic pneumonia

Duration

2 days

Due to advanced cardiac vascular disease.

years

Due to

Other Conditions Shock

5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Sept. 22 at 1:30 P. M.

(c) Where did injury occur? 2142 Hallins St.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? on front steps. While at work? no

(Specify type of place)

(e) Means of injury Fall to pavement.

23. Signature Edwin Fleming M.D.

Address 1904 W. Balto. St. Date signed 9-28-43

SEP 29 1943

affirmed by Thomas J. Mordue, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 08594	
CERTIFICATE OF DEATH		940	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>Ind.</u> (b) County	
(b) Street address		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution: <u>St. Vincent's Hosp</u>		(d) Street No. <u>1407 N. Gay St</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>P.O.A.</u>		(e) Citizen of foreign country? (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days)		If yes, name country	
3 (a) FULL NAME <u>Jacob Dorach</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No. <u>213-03-8570</u>	
4. Sex <u>M</u>	5. Color or race <u>W</u>	6 (a) Single, married, widowed, or divorced <u>married</u>	
6 (b) Name of husband or wife <u>Mamie Dorach</u>		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>June 11, 1877</u>			
8. AGE: Years <u>66</u>	Months <u>3</u>	Days <u>17</u>	If less than one day hr. min.
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)			
10. Usual Occupation <u>Salesman</u>			
11. Industry or business <u>Sanitary Supply Co.</u>			
12. Name <u>John F. Dorach</u>			
13. Birthplace <u>Germany</u>			
14. Maiden Name <u>Gertrude Ochs</u>			
15. Birthplace <u>Germany</u>			
16 (a) Informant <u>Mamie Dorach</u>			
(b) Address <u>1407 N. Gay St.</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>10/1/43</u> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Holy Redeemer</u> Location <u>Belair Road</u>			
18 (a) Funeral director <u>Howard N. Blight Jr.</u>			
(b) Address <u>4914 Belair Road</u>			
19 (a) <u>SEP 29 1943</u> (b) <u>Huntington Williams, M.D.</u>			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Sept. 28</u> 19 <u>43</u> , at <u>10⁵⁰</u> AM			
21. I certify that I took charge of the remains described above, held an <u>Inspection</u> thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to <u>his</u> death on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> and that the causes of death were: IMMEDIATE CAUSE OF DEATH <u>Coronary occlusion</u>			
Due to			
Other Conditions			
(Include pregnancy within 3 months of death)			
22. If an external cause was primary <input type="checkbox"/> or contributing <input type="checkbox"/> cause of death, fill in the following:			
(a) Date of injury at M.			
(b) Where did injury occur?			
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?			
(d) Means of injury			
23. Signature <u>Robert Lee Frutkin</u> M.D. Date signed <u>Sept. 28</u> 19 <u>43</u> Medical Examiner.			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT X G 08595
CERTIFICATE OF DEATH 119a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood Green
(c) Hospital or institution: Univ. Hospital 4
(d) Length of stay in hospital of inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elliott City
(If outside city or town limits write RURAL and give town)
(d) Street No. Beays
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Sullivan
3 (b) If veteran name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race white 6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 8 Months Days If less than one day hr. min.

9. Birthplace Howard Co., Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

12. Name Calvin Sullivan
13. Birthplace
14. Maiden Name Dorothy Norfolk
15. Birthplace Md

16 (a) Informant Calvin Sullivan
(b) Address Elliott City Md

17 (a) Burial (b) Date thereof 10-1-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Elliott City Md

18 (a) Funeral director H. J. [unclear]
(b) Address Elliott City Md

19 (a) SEP 29 1943
(Date rec'd by registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1943 at 8:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1943, to 9/28 1943, and that I last saw him alive on 9/28 1943.

Immediate cause of death Respiratory failure
Due to Dementia + alcohol

Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. [unclear] M.D.
Address Univ. Hospital Date signed 9-29-43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08596
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and location)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 SEP 20 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08597
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Emerson Hotel
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5400 Truchman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Junius Saunders
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 5, 1893

8. AGE: Years 50 Months 7 Days 10 hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation oil business

11. Industry or business self

12. Name C. Walton Saunders

13. Birthplace Richmond Va.

14. Maiden Name Bertrude Elgbrook

15. Birthplace Richmond, Va.

16 (a) Informant: wife
b) Address

17 (a) Burial (b) Date thereof 9/29/43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Richmond, Va.
Location

18 (a) Funeral director Wm. J. Tichant & Sons
(b) Address North & Penn Ave.

19 SEP 29 1943
(Date rec'd by registrar) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943 at 1:45 A

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were IMMEDIATE CAUSE OF DEATH Cornary occlusion

Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Date signed Sept. 29, 1943
Medical Examiner.

G 08598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08598

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2234 Broth St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

45 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Frank Remesch

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

12/24/1886

8. AGE:

Years

Months

Days

If less than one day

56

9

3

hr.

min.

9. Birthplace

Hungary

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Paul Stoffle

13. Birthplace

Hungary

14. Maiden Name

Barbara Sauer

15. Birthplace

Hungary

16 (a) Informant

Frank Remesch

(b) Address

2234 Broth St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10/18/43

(c) Cemetery or crematory

New Catholic

Location

Baltimore Md.

18 (a) Funeral director

F. B. WIPPERT, SON

(b) Address

Baltimore, Maryland

19 (a)

(Date rec'd by registrar)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore Md.

(If outside city or town, write RURAL and give town)

(d) Street No.

2234 Broth St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/27/45 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 9/27/43, and that I last saw her alive on 9/27/43.

Immediate cause of death

Malignancy of stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1946 N. Malt

Date signed 9/27/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

SEP 29 1943

G 08599

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08599

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2535 Remond St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2535 Remond St

(If rural give location)

(e) Citizen of foreign country?

2

(Yes or No)

If yes, name country

3 (a) FULL NAME

Lucella E. Lescallett

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

David Lescallett

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

11/2/1869

8. AGE:

Years

Months

Days

If less than one day

73

24

hr.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Chas F. Smith

13. Birthplace

Washington D.C.

MOTHER

14. Maiden Name

Mary Smith

15. Birthplace

Md

16 (a) Informant

Mrs Jones

(b) Address

2535 Remond St

17 (a)

(b) Date thereof

9/24/45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or repository

Lorraine Park

Location

Woodlawn Md

18 (a) Funeral director

F. B. WIPPERT & Son

(b) Address

300 E. Pratt Place

19 (a)

(b)

SEP 29 1945

Washington D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/26/45 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/45 to 9/26/45

and that I last saw him alive on 9/24/45

Immediate cause of death

Coronary thrombosis

Due to

Severe myocardial infarction

Due to

Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

F. B. WipPERT

Address

300 E. Pratt Place

Date signed

9/26/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

Duration

3 days

3 yrs

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 08600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 317 S. Bouldin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 317 S. Bouldin St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mamie Hintz

3 (b) If veteran, name war

3 (c) Social Security Account
No. ---

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Hintz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1889

8. AGE: Years 54 Months 7 Days 9 17 If less than one day hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER
MOTHER

12. Name William Baker

13. Birthplace Balto. Md.

14. Maiden Name Fredericks Horstman

15. Birthplace Germany

16 (a) Informant John Hintz

(b) Address 317 S. Bouldin St.

17 (a) Burial

(b) Date thereof Sept. 30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn Cem.

Location

Balto. Md.

18 (a) Funeral director

Philip H. H. Sons

(b) Address 2024 Orleans St.

SEP 20 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26/43 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31-1943 to 9-26-1943 and that I last saw her alive on 9-25-1943.

Immediate cause of death

Pulmonary Embolism

Due to Thrombo-phlebitis

Due to uterine Fibroid
arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. J. David

Address 3218 Eastern M. D. Date signed 9-28-43

Duration
5 minutes

3 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08601

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 810 Fitting Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
(c) City or town Batts.
(d) Street No. 810 Fitting Court
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Douglas, Sandra Irene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace Burblyn, Batts MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name James E Douglas

13. Birthplace Gatlin Ry

14. Maiden Name May Laramie Rowlett

15. Birthplace Harrogate Tenn.

16 (a) Informant Mrs. Keister

(b) Address 300 Potomac Ave

17 (a) Burial (b) Date thereof Sept 30-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or location Cedar Hill
Phila Highway

18 (a) Funeral director Milton Schilling

(b) Address 384 S. Hammond St

19 (a) SEP 28 1943 (b) Washington Williams, M.D.
(Date filed by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1943, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1943, to Sept 28 1943, and that I last saw her alive on Sept 28 1943.

Immediate cause of death

atalectasis

Due to

prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Philip W. Keister M.D.

Address 303 Potomac Ave

Date signed 9/28/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

441346 08602 BALTIMORE CITY HEALTH DEPARTMENT * G 08602
CERTIFICATE OF DEATH 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. yrs., mos., or days: **7**
(e) Length of stay in Baltimore yrs., mos., or days:

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md** (b) County **A. ARUNDEL**
(c) City or town **BROOKLYN** (If outside city or town limits, write RURAL and give town)
(d) Street No. **RFD #9 Box 198A** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **LORRAINE WHITAKER**
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Single**
6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr **9-1-35**
8. AGE: Years **8** Months **25** Days **hr min** If less than one day
9. Birthplace **Rio, W. VA** (Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name **Lee Whitaker**
13. Birthplace **W VA**
14. Maiden Name **W VA**
15. Birthplace **W VA**

16 (a) Informant **Records**
(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **Sept 30, 43**
(Burial, cremation, or removal) (month) (day) (year)
Location **Cedar Hill Cemetery**
Richie Highway, Balto Md

18 (a) Funeral director **Milton Schilling**
(b) Address **3914 E. Harrow St**
Washington, D.C.

19 (a) (Date rec'd by registrar) **SEP 29 1943** Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH **Sept 26 1943 at 10:00 P M**
21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 15 1943** to **Sept 26 1943**, and that I last saw her alive on **Sept 26 1943**.
Immediate cause of death **Hypertension**
Heart failure (3) nephritis
pulmonary oedema
Due to **(5) nephritis cystitis**
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature **Hebe Bowie**
Address **Johns Hopkins Hosp.** Date signed **9/27/43**

PHYSICIAN
Underline the cause to which death should be charged statistically.

08603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08603
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Elizabeth

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.)

Aug. 15, 1914

8. AGE:

Years

Months

Days

If less than one day

29

1

13

hr.

min.

9. Birthplace

Baltimore Co., Md.

(Town, county, and state)

10. Usual Occupation

Rigger

11. Industry or business

Bethlehem Fairfield

FATHER

12. Name

Geo. W. Hoffman

13. Birthplace

Baltimore Co., Md.

MOTHER

14. Maiden Name

Margaret Brooks

15. Birthplace

Baltimore Co., Md.

16 (a) Informant

Elizabeth Hoffman

(b) Address

704 W. Cross St

17 (a) Burial

(b) Date thereof 10-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Glen Haven

Location

Glenburnie, Md.

18 (a) Funeral director

Geo. H. Linnbach

(b) Address

525 N. Lincolnton St

SEP 29 1943

(Date filed by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 704 W. Cross Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1943 at 6:00 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Liver

and right kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/28/43 at 2 P. 25/6 M

(b) Where did injury occur? Bethlehem & Fairfield

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes

(d) Means of injury Truck in street by falling

23. Signature Robert L. Gratch, M.D.

Medical Examiner.

Date signed Sept 29 1943 steel

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08604

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2723 Oakley St.

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2723 Oakley St.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME Eva A. O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Charles E. O'Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1890

8. AGE: Years 63 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Roger Scott

13. Birthplace Va.

14. Maiden Name Rosa Candle

15. Birthplace Va.

16 (a) Informant Ann Schaefer

(b) Address 2723 Oakley St.

17 (a) Burial (b) Date thereof 9/23/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery encasement Cathedral

Location Richmond, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1943 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1942 to Sept 1943 and that I last saw her alive on Aug 1943.

Immediate cause of death

Hypertensive Cerebral Disease

Due to Cerebral Hemorrhage

Due to Cardiac Embolism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alex A. Weinstein, M.D.

Address 4603 Park Heights Ave. Date signed

Duration

3-4 yrs

2 years

3 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 29 1943

G 08605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08605

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital 9-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.(b) County Harford(c) City or town Pylesville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Edward J. Wharton

3 (b) If veteran, name war

3 (c) Social Security Account

No.

None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 4, 1921

8. AGE: Years

22

Months

0

Days

29

If less than one day

hr.

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

Farming

FATHER

12. Name

John Wharton

13. Birthplace

Pylesville, Md.

MOTHER

14. Maiden Name

Catherine Wharton

15. Birthplace

Harford Co. Md.

16 (a) Informant

John Wharton

(b) Address

Pylesville, Md.

17 (a)

Burial, cremation, or removal

Burial

(b) Date thereof

Oct. 2, 1943

(month) (day) (year)

(c) Cemetery or crematory

St. Mary's

Location

Pylesville, Md.

18 (a) Funeral director

J. H. H. H. H. H.

(b) Address

Pylesville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943, at 5:30 A

21. I certify that I took charge of the remains described above, held an

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

fracture of

skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Sept. 27, 1943 3:00 A(b) Where did injury occur? Perry Hall, Ind.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public Place While at work? no(d) Means of injury Run into truck23. Signature Robert L. Frater M.D.

Medical Examiner.

Date signed Sept. 29, 1943

SEP 29 1943

(b)

Huntington Hall, Md.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08606

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 200 E Preston St.

(c) Hospital or institution:

at home(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 11(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

3 (a) FULL NAME

3 (b) If veteran, name was

- No -

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

Single

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

July - 9 - 1881

8. AGE:

Years

Months

Days

62220

If less than one day

hr.

min.

9. Birthplace

Phila - Pa.

(Town, county, and state)

10. Usual Occupation

retired musician

11. Industry or business

FATHER

12. Name

Joseph Hazazer

13. Birthplace

Phila. Pa.

14. Maiden Name

Catherine Hunt

15. Birthplace

Phila. Pa.

16 (a) Informant

Mrs. Florence E. Hazazer (wid)

(b) Address

200 E Preston St.17 (a) burial

(b) Date thereof

Oct. 1 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

North Cedar Hill

Location

Frankford - Phila. Pa.

18 (a) Funeral director

Stewart Morris Co.

(b) Address

188 W North Av.

19 SEP 29 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

200 E Preston St.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 29 1943 at 4 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1943 to 9/29 1943, and that I last saw him alive on 9/28 1943.

Immediate cause of death

Cardiac hypertrophy
arterio Y infarct developing
for years.

Due to

chronic arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John T. Chasara

Address

804 Cathedral St.

Date signed

9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

437457
G 08607BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08607

Registered No.

73

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ANNA GREEN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-76

8. AGE: Years Months Days If less than one day
67 7 2 hr. min.

9. Birthplace

VA

(Town, county, and state)

10. Usual Occupation

home

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

EMMA TAYLOR

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

Sept. 29, 1943

(c) Cemetery or crematory

Location

Fort Royal, Va.

18 (a) Funeral director

Mrs. George W. Holland

(b) Address

1631 Druid Hill Ave.

Huntington, Williams, Md.

19 SEP 30 1943

VS 120

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 Mountmer Ct

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1943 at 10:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943 to Sept 27 1943 and that I last saw her alive on Sept 27 1943

Immediate cause of death Septicemia + Pulmonary Edema

Duration 3 mos.

Due to E. Coli. Alpha strep. fecalis.

Due to

Other Conditions Rupture of bladder.

(Include pregnancy within 3 months of death)

Date of operation 7/8/43

Major findings of operations: Carcinoma of Bladder

of autopsy: - not performed -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Spicholas J. Kohlerman

Address The Johns Hopkins Hospital Date signed 9/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08608

131a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 701 Baker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Robert J. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

84 yrs

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Mary A. Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1859

8. AGE: Years Months Days If less than one day
84 7 24 hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name James A. Wilson

13. Birthplace Md

14. Maiden Name Sallie Reeder

15. Birthplace Md

16 (a) Informant Wendel Wilson

(b) Address 701 Baker St

17 (a) Buried (b) Date thereof 9-30-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Nelson

(b) Address 1303 Presstman St

SEP 30 1943 (b) Huntington Williams, Jr.
(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 701 Baker St
(If rural give location)

(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1943 to Sept 26 1943, and that I last saw him alive on Sept 26 1943.

Immediate cause of death

Cardio-Vascular-Renal disease

Due to -

Due to -

Other Conditions Sensitivity etc
Hemiparesis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. B. Sturges

Address 825 N. Fremont St Date signed 9/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH *94a* **G 08609** *Registered No.*

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *REDWOOD + GREENE STS.*
(c) Hospital or institution: *UNIVERSITY HOSPITAL*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *19*
(e) Length of stay in Baltimore (yrs., mos., or days) *60*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md.* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1506 West N. 11th St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No) *No*

3 (a) FULL NAME *Milton R Pastor Field*
3 (b) If veteran, name war **3 (c) Social Security Account No.**

4. Sex *MALE* **5. Color or race** *WHITE* **6 (a) Single, married, widowed, or divorced.** *SINGLE*
6 (b) Name of husband or wife. **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr.) *1883*
8. AGE: Years *60* Months Days If less than one day hr. min.

9. Birthplace *MARYLAND* (Town, county, and state)
10. Usual Occupation *ELEVATOR OPERATOR*
11. Industry or business *B.O. R.R.*

12. Name *WM.*
13. Birthplace *MARYLAND*
14. Maiden Name *CAROLINE LLOYD*
15. Birthplace *MARYLAND* *WARRICK*

16 (a) Informant *MRS. CAROLINE HOGGALTT*
(b) Address *3328 MINDAWMIN AVE, CITY*
17 (a) BURIAL (b) Date thereof *9 30 43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Location *FORTON, MARYLAND*

18 (a) Funeral director *Jay H. Wright*
(b) Address *4101 Chambers Ave. City*

19 *SEP 30 1943* **(b)** *Dr. R. L. Embury* **Registrar**

MEDICAL CERTIFICATION
20. DATE OF DEATH *9-29 1943* at *7:30 AM*
21. I certify that death occurred on the date above stated; that I attended deceased from *9-22 1943* to *9-29 1943*, and that I last saw him alive on *9-29 1943*.
Immediate cause of death *Coxsacke pneumonia & possibly pulmonary embolism.*
Due to *Heart Failure*
Due to
Other Conditions *Pulmonary edema and chronic bronchitis.*
(Include pregnancy within 3 months of death)
Date of operation *None*
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature *[Signature]* **M. D.**
Address *1111 N. 11th St.* **Date signed** *9-29-43*
For R. L. Embury, affixed by Howard J. Macken, Jr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08610

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d G 08610
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1934 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 W Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Frances K. Gashus

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-10-7084

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 66 Months Days If less than one day
hr. min.

9. Birthplace

Lith
(Town, county, and state)

10. Usual Occupation

11. Industry or business

Sailor

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Edward Gashus

(b) Address 1934 W Fayette St

17 (a) Burial (b) Date thereof Oct 2-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Rd
Location Frederick Rd

18 (a) Funeral director Joseph Kamskas Inc

(b) Address 602 W Washington Blvd

(c) Huntington Williams M.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 28 1943 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 7 1943 to SEPT 28 1943 and that I last saw him alive on SEPT 28 1943.

Immediate cause of death

Coronary Thrombosis

Due to Arteriosclerosis

Myocardial Infarction

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: NO

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Edward J. Milam M.D.

Address 602 W Washington Blvd Date signed 9-29-43

Duration
2 DAYS

PHYSICIAN

Underline the cause to which death should be charged statistically.

19 SEP 30 1943
VS 150

G 08611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08611

Registered No.

93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 603 S. ROBINSON ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

3 (a) FULL NAME

IRENE E. LAWRENCE

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife JOHN W. LAWRENCE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 7 1884

8. AGE: Years Months Days If less than one day

58

10

20

hr.

min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JOHN E. OWNS

13. Birthplace BALTO. MD.

14. Maiden Name KATHERINE BROWN

15. Birthplace BALTO. MD.

16 (a) Informant LEROY W. LAWRENCE (SON)

(b) Address 603 S. ROBINSON ST.

17 (a) BURIAL (b) Date thereof OCT. 1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE. EXT.

18 (a) Funeral directors Lilly and Zeller INC.

(b) SEP 30 1943 S. WOLFE ST.

19 (a) (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 603 S. ROBINSON ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH SEPT. 27 19 43 11/45M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 19 43, to Sept 27 19 43, and that I last saw her alive on Sept 27 19 43.

Immediate cause of death

Coronary Occlusion

Due to

Arterio-Sclerotic Hypertension

Due to

Myocardial Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph Quindler

Address 1701 E. Fayette St. Date signed 9/28/43

Duration

2 days

4 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08612

93d Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3 N. East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3 N. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George W. Dougherty

3 (b) If veteran, name war

no.

3 (c) Social Security Account

No. none.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mary Dougherty

6 (c) If alive, give age

67 years

7. Birth date of deceased (mo., day, yr.)

Aug 23 - 1874

8. AGE:

Years

Months

Days

If less than one day

72 71.

1

6.

hrs. min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

Salmon

11. Industry or business

FATHER

12. Name

George W. Dougherty

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Mary Cronin

15. Birthplace

Baltimore Md.

16 (a) Informant

George W. Dougherty

(b) Address

3 N. East Ave.

17 (a)

Burial

(b) Date thereof

Sept. 30 1943

(c) Cemetery or crematory

Oak Lawn

Location

Eastern Ave

18 (a) Funeral director

Wardell M. Mispel

(b) Address

312 S. Highland Ave.

19 (a)

Huntington

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943 at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1943 to Sept 29 1943, and that I last saw him alive on Sept 29, 1943.

Immediate cause of death

Coronary Arteriosclerosis
Coronary Thrombosis

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Allen L. Beetham

Address

312 S. Highland Ave.

Date signed 9-29-43

M. D.

SEP 30 1943

ALLEN

BEETHAM

08613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08613
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

Baltimore

(c) City or town

Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No.

929 Pittsburg Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

(Ben)

Benjamin N. Taylor (Benjamin Taylor)

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-10-2455

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male

Colored

Married

6 (b) Name of husband or wife

Geneva Taylor

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

May 16, 1891

8. AGE: Years

Months

Days

If less than one day

57

51

4

12

hr.

min.

9. Birthplace

Guilford County, N.C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Remann Copper Works

12. Name

Richard Taylor

13. Birthplace

N.C.

14. Maiden Name

Sallie —

15. Birthplace

N.C.

16 (a) Informant

Geneva Taylor

(b) Address

929 Pittsburg Ave.

17 (a) Burial

(b) Date thereof

Oct 1, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Fellows Memorial Park

Location

18 (a) Funeral director

Robert L. Young

(b) Address

104 W. Caroline St.

(c) Name of Registrar

Huntington Williams, M.D.

Date of death

SEP 20 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 28, 1943, at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Toxemia due

to second degree burns.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH119a G 086
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp. 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1220 E. Madison St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Raymond Johnson

3 (b) If veteran, name war

(c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 29, 1942
If less than one day

8. AGE: Years

Months

Days

1 12 29 hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Ollie Battle

13. Birthplace

N.C.

14. Maiden Name

Pattie Johnson

15. Birthplace

Va.

16 (a) Informant

Ollie Battle

(b) Address

1220 E. Madison St.

17 (a)

Burial

(b) Date of death

Oct. 1, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Robert L. Conner

(b) Address

804 W. Caroline St.

19 (a)

9/30/43

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1943, at 6:30 AM

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Infantile
diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Conner M.D.

Medical Examiner.

Date signed Sept. 29, 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08615 3629 Edm

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 2
47

08615

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2117 Decatur St.

(c) Hospital or institution

Crawford Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3008 Liberty Heights Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Nellie Hook

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

1887

8. AGE:

Years

Months

Days

If less than one day

56

hr.

min.

9. Birthplace

Baltimore, Ind.

(Town, county, and state)

10. Usual Occupation

Home Duties

11. Industry or business

12. Name

William Landell Hook

13. Birthplace

Maryland

14. Maiden Name

Elizabeth Halton

15. Birthplace

Maryland

16 (a) Informant

Carroll Hook

16 (b) Address

3008 Liberty Heights Ave.

17 (a) Burial

(b) Date thereof

Oct 1 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Baltimore

18 (a) Funeral director

Frank G. Syfer

(b) Address

1600 W. North Ave.

19

SEP 30 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/25

1943, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/25 1943, to 9/25 1943,

and that I last saw her alive on 9/27 1943.

Immediate cause of death

General Visceral Failure

Duration

1 yr

Due to

PULMONARY CARCINOMA

(LEFT)

4 yrs?

Due to

Other Conditions

PERNICIOUS ANEMIA

P.O. BRONCHIAL FISTULA

(Include pregnancy within 3 months of death)

Date of operation

9/30/41 LABORATORY

Major findings of operation:

PULMONARY

CARCINOMA

of autopsy:

10 yrs?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Thos E. Conner

Address 3629 Edmondson

Date signed 9/30/43

08616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08616
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4104 Kathlamet Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4104 Kathlamet Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles E. Slonaker

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced.

Widower

6 (b) Name of husband or wife

Mary A. Slonaker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 2-1857

8. AGE:

Years

Months

Days

If less than one day

86

2

27

hr.

min.

9. Birthplace

Carroll County Md

(Town, county, and state)

10. Usual Occupation

Retired Contractor

11. Industry or business

FATHER

12. Name

Andrew Slonaker

13. Birthplace

Carroll County - Md

MOTHER

14. Maiden Name

Amanda

15. Birthplace

Carroll County Md

16 (a) Informant

Charles E. Slonaker

(b) Address

4104 Kathlamet Ave

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location

Woodlawn Trl

18 (a) Funeral director

Mamie Cook Syfer

(b) Address

1600 W. North Ave

SEP 30 1943

(Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 29 1943 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan 1 1941 to Sept 29 1943.

and that I last saw him alive on Sept 28 1943

Immediate cause of death

Coronary occlusion

Due to

arterio-sclerosis

Due to

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Walter P. Thibault

M. D.

Address 2220 Harrison

Date signed

Sept 20/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08617

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1011 E. Fayette St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C.

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
21 hr. min.9. Birthplace Baltimore
(Town, county, and state)10. Usual Occupation Laborer

11. Industry or business

12. Name Frank Stewart13. Birthplace Baltimore14. Maiden Name Lena Bailey15. Birthplace Baltimore16 (a) Informant Lena Bailey(b) Address 1029 Somerset St17 (a) Burial (b) Date thereof 9-30-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Calvary Cem.
Location D. A. Co.18 (a) Funeral director Rayner Sanders(b) Address 1412 E. Preston St
Huntington Williams, Md.

SEP 30 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1943, at 8:27 AM21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Coronary
occlusionDue to Arteriosclerosis of left
coronary artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.Date signed Sept. 26 1943
Medical Examiner

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08618

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08618
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2309 Ken Oak Avenue
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Ken Oak Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Flora Hoffman Tarun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Dr. William Tarun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1867

8. AGE: Years 76 Months 1 Days 0 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Daniel V. Hoffman
13. Birthplace Baltimore County, Md.

14. Maiden Name Barbara Cline
15. Birthplace Va.

16 (a) Informant Dr. William Tarun
(b) Address 2309 Ken Oak Road

17 (a) Burial (b) Date thereof 10/1/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Bayview Place

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th 1943 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941 to Sept 28 1943, and that I last saw her alive on Sept 28 1943.

Immediate cause of death

Cerebral arterio-sclerosis

Duration

145.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature Harry D. McCarty
Address 37 W. Preston St. Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 30 1943

H. A. Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08619

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address: 1811 Smallwood St
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:

- (a) State: ~~MD~~ (b) County: ~~Baltimore~~
(c) City or town: ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1811 Smallwood St
(e) Citizen of foreign country? (Yes or No) ☒

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Elleu F. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female white

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

69 2 21 hr. min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual Occupation

home duties

11. Industry or business

FATHER

12. Name

Charles N. Dorsey

13. Birthplace

Balto.

MOTHER

14. Maiden Name

Hannah Cathers

15. Birthplace

Balto.

16 (a) Informant

Miss Caroline S. Dorsey

(b) Address

1811 Smallwood St

17 (a) ~~Cremation~~

(b) Date thereof Oct 4/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Landon Park

Location

3801 Frederick Ave.

18 (a) Funeral director

John O. Mitchell

(b) Address

1900 Entwain Place

19 (a)

2019

(Date of burial)

2019

(Date of death)

2019

(Date of death)

2019

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1943

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 20-1943 to Sept 29 1943 and that I last saw her alive on 9-29-1943

Immediate cause of death

Carcinoma of spinal cord

Due to Carcinoma of breast

Due to

Other Conditions Chronic arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

SIGMAR PIROSH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08620

Registered No.

830

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 803 Cathedral St.

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Towson

(If outside city or town limits, write RURAL and give town)

(d) Street No. 316 Weatherbee Road

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Murray Waters Tinges

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-05-9347

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Marguerite Johnson

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 3, 1889

8. AGE: Years Months Days If less than one day

54

5

26

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Cummins Construction Co.

12. Name Henry M. Tinges

13. Birthplace Baltimore, Md.

14. Maiden Name Emily J. Waters

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marguerite Tinges

(b) Address 316 Weatherbee Rd., Towson, Md.

17 (a) Burial (b) Date thereof 10/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Son, Inc.

(b) Address 1900 Eutaw Place

19 (a) (b) Registrar

VB 114

SEP 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1943 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1942 to 9-7 1943, and that I last saw him alive on 9-7 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

Sudden

Due to Arteriosclerosis by perforation

Due to

Other Conditions none

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

none

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. McLean M. D.

Address 795 Medical Arts Bldg. Date signed

J. McLean

08621

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 08621

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 504 Mount Holly ST., 7 WARD)

2. FULL NAME

Helen M. Herbert

(a) RESIDENCE NO.

504 Mt. Holly ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of

or) WIFE of

Harry F. Herbert

6 DATE OF BIRTH (month, day, and year)

Jan 16 - 1886

7 AGE

Years

Months

Days

If LESS than
1 day, ___ hrs.
or ___ min.67812

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Carl K. Luth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant

(Address)

Harry F. Herbert
504 Mount Holly St

15

Informant

(Address)

Huntington Williams
1111

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 28 - 1943

17

I HEREBY CERTIFY, That I attended deceased from

Sept 24, 1943, to Sept 28, 1943,that I last saw her alive on Sept 27, 1943,and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

Atherosclerosis(duration) 8 yrs. ___ mos. ___ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Physical Examination(Signed) J. W. Bellamy M. D., 19 (Address) 224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

DATE OF BURIAL

Oct 1st 1943

20 UNDERTAKER

Wilbur W. Sherrill Inc

ADDRESS

4130 Edmonda Ave

SEP 30 1943

G 08622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08622

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 30 1943

VB 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08623

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08623

Registered No.

172

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Ave. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 728 Hanover Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1900

8. AGE:

Years

Months

Days

If less than one day

43

hr.

min.

9. Birthplace

Kingston (B. W. I.)

(Town, county, and state)

10. Usual Occupation

Saloon

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof 10-2-43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

SEP 30 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1943, at 11:20 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-28- at 9:10 A.M.

(b) Where did injury occur Harbor for Chesapeake Bay

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes

(d) Means of injury Fall from scaffolds, aboard ship.

23. Signature Howard J. Williams M.D.

Date signed 9-28-43 Medical Examiner.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08624
JL - 83903BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08624
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) **8 Days**
(e) Length of stay in Baltimore (yrs., mos., or days) **35 yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **147 Henrietta St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Hayes

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C6 (a) Single, married, widowed, or
divorced. **Sept.**

6 (b) Name of husband or wife

?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 11, 1886

8. AGE: Years

57

Months

3

Days

16

If less than one day

hr.**min.**9. Birthplace **N. C.**

(Town, county, and state)

10. Usual Occupation

Janitor Work

11. Industry or business

FATHER
MOTHER12. Name **Samuel Hayes**

13. Birthplace

N. C.14. Maiden Name **Ve. Rogers**

15. Birthplace

N. C.16 (a) Informant **B. C. H. Records**

(b) Address

4940 Eastern Ave.17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **10-1-43**

(month) (day) (year)

(c) Cemetery or crematory

Mount Calvary CtLocation **A. A. Co. Md**18 (a) Funeral director **Isaiah L. Brown**(b) Address **108 W. Montgomery St****SEP 30 1943**

(Date rec'd by registrar)

H. J. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/27 1943 at 7:55 AM21. I certify that death occurred on the date above stated; that I attended
deceased from **9/20 1943** to **9/27 1943**
and that I last saw him alive on **9/27 1943**

Immediate cause of death

**Cardiac
failure, post. cerebral
embolus
Due to
acute CV disease
on
chronic CV
Due to
decompensation**

Duration

2-3 hr

Other Conditions

**Gen. arterio-
sclerosis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

**Subacute infarct of brain
acute & rupture of aortic valve
of autopsy**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?
(e) Means of injury

23. Signature

E. L. Sargman

Address

BCHDate signed **9/27**

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08625
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Greene + Lombard
 (c) Hospital or institution: University Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 4
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 123 Pearl Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Paul E. Reese

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 19438. AGE: Years Months Days If less than one day
2 18 hr. min.9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Des. Barker Reese13. Birthplace Ohio14. Maiden Name Dorothy Reese15. Birthplace Michigan16 (a) Informant Dorothy Reese(b) Address 123 Pearl Street17 (a) Burial (b) Date thereof 10-1-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md.18 (a) Funeral director Mr. Cook & Sons(b) Address 1217 St. Paul St.19 (a) SEP 30 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1943 at 10 10 M21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Pulmonary edemaMeasur tracheadenitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.Date signed Sept 30 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a 08626
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address RAYNER AVE, DUKELAND ST

(c) Hospital or institution: WEST BALTO. GENERAL HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt.

(d) Street No 3012 Wylie Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

MR LEVIN WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ida Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15 1860

8. AGE: Years 83 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Salisbury Md.

10. Usual Occupation Retired

11. Industry or business Barber

FATHER

12. Name Wilson

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs M Jutosh

(b) Address 3012 Wylie Ave

17 (a) Burial (b) Date thereof 10/1/43

(c) Cemetery or crematory Woodlawn

Location Md

18 (a) Funeral director Williams Book Inc

(b) Address 1217 St. Paul St.

19 SEP 30 1943

(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/43 19 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/43 to 9/29/43, and that I last saw him live on 9/29/43.

Immediate cause of death Cardiac Failure

Due to Hypertensive Cardiac - vascular renal disease

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theodore J. Jutosh MD

Add West Baltimore Hosp Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08627

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08627

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1119 E. 20th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1119 E. 20th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Annie Amollie Nachman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Samuel H. Nachman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1890

8. AGE: Years Months Days If less than one day
73 4 15 hr. min.

9. Birthplace

Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Anneil H. Taylor

13. Birthplace Unknown

14. Maiden Name Mary T. Rex

15. Birthplace Unknown

16 (a) Informant Rose Taylor

(b) Address 1119 E. 20th St

17 (a) Burial (b) Date thereof 10/10/43
(Burial, cremation, or reinterment) (month) (day) (year)

(c) Cemetery or crematorium Okeb Shalom
Location Balto Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 SEP 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1943 9:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 19 1942 to Sept 29 1943, and that I last saw her alive on Sept 25 1943.

Immediate cause of death

Acute Coronary Arteriosclerosis

Due to Chronic Myocardial Ischemia

Due to Coronary Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harry Hyde

Address 11008 N. Dan Date signed 9/30/43

HARRY HYDE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3311 Beverly Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Albert M. Reinhardt Jr.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-01-1920

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife. Roberta E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1899

8. AGE: Years 44 Months 1 Days 16 If less than one day hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

12. Name Albert M. Reinhardt

13. Birthplace Md.

14. Maiden Name Anna S. Hopper

15. Birthplace Md.

16 (a) Informant Mrs. Roberta E. Reinhardt

(b) Address 3311 Beverly Road

17 (a) Burial (b) Date thereof Oct 1, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave

18 (a) Funeral director William M. Marack

(b) Address 715 Light St.

19 SEP 30 1943 (Date rec'd by registrar) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 3311 Beverly (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1943 at 4:17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1942 to 9-29 1943 and that I last saw him alive on 9-29 1943.

Immediate cause of death

Uremia

Due to Chronic Nephritis 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. W. Pugh

Address 4503 Harford Rd Date signed 9-29-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08629

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08629
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 307 E. Cross St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

William E. Bayne

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-09-1905

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife B. Christina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1894

8. AGE: Years Months Days If less than one day

49 7 219 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

12. Name William C Bayne

13. Birthplace Md

14. Maiden Name Carrie E Edward

15. Birthplace Md

16 (a) Informant Mrs B Christina Bayne

(b) Address 307 E Cross St

17 (a) Burial (b) Date thereof 27 Oct 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Frederick Ave

18 (a) Funeral director William M Mareck

(b) Address 715 Light St

19 SEP 30 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1943 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1943 to Sept 28 1943, and that I last saw him alive on Sept 28 1943.

Immediate cause of death

Bronchogenic carcinoma
- metastatic.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul H. Lubato

Address 1213 Light St. Date signed 9/28/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FOR FILING

08630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08630
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1017

N. Charles St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

GRACE

E

MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/1927 1927

8. AGE: Years

16

Months

0

Days

10

If less than one day

hr.

min.

9. Birthplace

Liverpool, Pa.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Pepsi Cola Co.

FATHER
MOTHER

12. Name William A. Miller

13. Birthplace Liverpool, Pa.

14. Maiden Name Stella E. Yreago

15. Birthplace Richfield, Pa.

16 (a) Informant William A. Miller

(b) Address Liverpool, Pa.

17 (a)

Burial

(b) Date thereof

10/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Livingston, Pa.

Location

Livingston, Pa.

18 (a) Funeral director

John P. Bluman

(b) Address

4400 E. Charles St.

SEP 30 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1943 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Asphyxiation

Due to

Carbon monoxide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-29-43 at 11:20 M.

(b) Where did injury occur? above address

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?

(d) Means of injury water heater

23. Signature H. Z. Wallensten M.D.

Date signed 9-30-43

Medical Examiner

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08631
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 234 S. Ann street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 9 years

3 (a) FULL NAME

Maryanna Kawalski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Steven Kawalski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 19 1883

8. AGE: Years Months Days If less than one day

60

8

8

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

FATHER

12. Name

Frank Asley

13. Birthplace

Poland

MOTHER

14. Maiden Name

Dorothy Kruszkowska

15. Birthplace

Poland

16 (a) Informant

Mrs. Cecilia Rembicki

(b) Address

232 S. Ann Street

17 (a)

Burial

(b) Date thereof

Sep 30 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Rosary Cem.

Location

Baltimore County

18 (a) Funeral director

John M. Welch

(b) Address

401 S. Chester St.

SEP 30 1943
Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 234 S. Ann Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 27 1943 at 9 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1943 to Sept. 27 1943 and that I last saw him alive on Sept. 27 1943.

Immediate cause of death

Sanguine of Rt foot + Leg
Septicemia + Cordis-Ventricular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Huntington Williams

Address 2579 Eastern Ave.

Date signed

M. D.

9/28/43

8532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08632
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State NY (b) County Manhattan(c) City or town New York
(If outside city or town limits, write RURAL and give town)(d) Street No. 73 - 7th Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN BRANTON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

50

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL SEP 30 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 30 1943
(Date for use by Registrar)(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1943 at 8:30 M

21. I certify that I took charge of the remains described above, held an
autopsy, inspection or inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased cameto his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions he

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 9-21-43 6:30 a M

(b) Where did injury occur? 800 5th Ave Rd

(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work?

(d) Means of injury Pedestrian struck by auto

23. Signature H. Z. Wollemstein, M.D.

Date signed 9-21-43

Asst. Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 08633**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *0 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *506 Orchard St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY

BATTS Twin #2

3 (b) If veteran, name war

3 (c) Social Security Account No. *-*

4. Sex

F

5. Color or race

C.

6 (a) Single, married, widowed, or divorced

-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

2 hr. min.

9. Birthplace

Baltimore Md.
(Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Susan Batts

15. Birthplace

Baltimore, Md

16 (a) Informant

Susan Batts

(b) Address

506 Orchard St.

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL SEP 30 1943*

18 (a) Funeral director

Commissioner of Health

(b) Address

SEP 30 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 26 1943 at 2 P.M.*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *her* death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia, lobular

Due to *Prematurity*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *H. L. Wallenwater M.D.*

Date signed *9-27-43*

Medical Examiner.

0407

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08634

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

50

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 30 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19

SEP 30 1943 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 285 N. Enoch St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1943, at 5:40 M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial
Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Graham

M.D.

Date signed

Sept 18 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08635
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 731 W. Lexington St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

LESLIE

HALL

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 15 1904

8. AGE:

Years

Months

Days

If less than one day

39

-

01

hr.

min.

9. Birthplace

Hartford N.C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name Emanuel Hall

13. Birthplace

N.C.

MOTHER

14. Maiden Name Katie Melton

15. Birthplace

N.C.

16 (a) Informant

Morton Hall (brother)

(b) Address

744 N. Franklin St

17 (a)

Burial

(b) Date thereof

9-30-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hall Cemetery

Location

Crosfield N.C.

18 (a) Funeral director

Charles B. Cooper

(b) Address

1701 Calhoun St.

19

SEP 30 1943

(b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943, at 11 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Bullet wound of chest
+ abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ of contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-26-43, at 10:45 P.M.

(b) Where did injury occur? 731 W Lexington St

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?

(d) Means of injury Revolver - altercation

23. Signature H. W. Williams, M.D.

Date signed 9-27-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08636

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Me.

(b) County Hanford

(c) City or town Aberdeen

(If outside city or town limits, write RURAL and give town)

(d) Street No. R.F.D. #1

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

May A. (Mallie) Anderson

3 (b) If maiden, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1862

8. AGE: Years Months Days If less than one day

81

1

12

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name Henry S. Anderson

13. Birthplace Maryland

MOTHER

14. Maiden Name May A. Harris

15. Birthplace Maryland

16 (a) Informant Miss Marion Allen

(b) Address 4005 Harwood Rd. Baltimore, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 2, 1943

(month) (day) (year)

(c) Cemetery or crematory Baham Cem.

Location Aberdeen, Md.

18 (a) Funeral director

Henry J. Jarrin, Jr.

(b) Address Aberdeen, Md.

SEP 30 1943

Registrar

VB 100

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1943, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23, 1943, to Sept 29, 1943, and that I last saw her alive on Sept 26, 1943.

Immediate cause of death

Carcinoma of ovary

Duration

2-3 yrs?

Due to

Due to

Other Conditions

ascites

(Include pregnancy within 3 months of death)

Date of operation Sept. 1943

Major findings of operations: Carcinoma

of ovary

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Isabella Harrison

Address Church Home & Hosp. Date signed 7-29-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 08637

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08637
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 N. Broadway, Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPH BERNARD HEARD

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1898

8. AGE: Years Months Days If less than one day
45 6 3 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Rustless Steel-8 mos. ago

12. Name Robert J. Heard

13. Birthplace Md.

14. Maiden Name Catherine Carew

15. Birthplace Md.

16 (a) Informant Records, U.S. Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Oct 1 - 43.
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Trueman Rd. Extended

18 (a) Funeral director J. Lee Oder

(b) Address 4644 York Rd.

19 (a) (b) *Amington Williams, M.D.*

SEP 30 1943

MEDICAL CERTIFICATION

F.

20. DATE OF DEATH Sept. 28, 1943, at 3:35 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept. 22, 1943, to Sept. 28, 1943,
and that I last saw him alive on Sept. 28, 1943.

Immediate cause of death Ruptured duodenal
ulcer with peritonitis

Duration
Sept. 27

Due to

Due to

Other Conditions Bronchopneumonia

Unk.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(e) Means of injury

23. Signature *J. Lee Oder*

Address Baltimore, Md.

Date signed 9/28/43

Va-13738

G 08638

BALTIMORE CITY HEALTH DEPARTMENT

G 08638

CERTIFICATE OF DEATH / 47a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Md.
 (c) Hospital or institution: Johns Hopkins Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1708 N. Chapel St.
 (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

GEORGE MORTIMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Elizabeth6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, year)

Aug 9 - 1873

8. AGE: Years

Months

Days

If less than one day

70121

hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Fireman

11. Usual Residence

Baltimore, Md. 1708 N. Chapel St.

FATHER

MOTHER

12. Name

13. Birthplace

Thomas MortimerMd.

14. Maiden Name

Gennie Booth

15. Birthplace

Md.

16 (a) Informant

Mrs. Edg. Mortimer

(b) Address

1708 N. Chapel St.

17 (a)

(b) Date thereof

Bureau10-4-43

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

18 (a) Funeral director

Wheeler, E. Humphrey

(b) Address

201 N. Broadway

19 (a)

Date of death

SEP 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1943, at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carcinoma of the larynx.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature

J. J. Williams

M.D.

Date signed

9-30-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08639

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08639
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 722 S. 33rd St. - Roomer

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Rebecca - 7

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

45

hr.

min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual Occupation

Bar Tender

11. Industry or business

FATHER
MOTHER

12. Name

James Kelly

13. Birthplace

Pa

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Myrtle Baine

Location

18 (a) Funeral director

(b) Address

J. J. Fagan Sons
11318 Light St.SEP 30 1943
(Date filed by Registrar)Huntington Williams, M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1943, at 11 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Howard J. Mulcahy

M.D.

Date signed 9-30-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08640

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2740 Ellicott Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

3 (a) FULL NAME

Helen T. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No. no.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Patrick Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29th 1877

8. AGE: Years 66 Months - Days 28 hr. min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Unknown

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant William Coleman

(b) Address 1 Lanthier Heights

17 (a) ~~burial~~ (b) Date thereof Oct 1, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Catholic Am.

Location Old Frederick Rd.

18 (a) Funeral director Charles F. Dell

(b) Address 1501 E. Ford Ave.

SEP 30 1943

(Date received by Registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County -

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2740 Ellicott Avenue
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 27, 1943, 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31/1943 to 9/27/1943 and that I last saw her alive on 9/26/1943.

Immediate cause of death

Hypertensive cardio 6:40 AM
vascular renal disease

Due to

Due to

Other Conditions Uraemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harry Berdel

Address 1226 Hanover St., Date signed 9/29/43

Duration

5 mos.

27 days

2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08641
T.M. 84021

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08641
Registered No. 465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
1519 W. Lanvale St
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Chase

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 27th 1877

8. AGE: Years 65 Months 9 Days 1 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name Samuel Chase

13. Birthplace Maryland

14. Maiden Name Elizabeth ?

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Oct 4, 1943 (month), (day) (year)

(c) Cemetery or crematory Mount Lebanon Cemetery Location Baltimore County

18 (a) Funeral director Joseph A. Sapp

(b) Address 408 N. Mount Street

19 (a) 30-1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1943, 11:30 A

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1943, 9/28 1943 and that I last saw him alive on 9/28 1943.

Immediate cause of death: Co of stomach 2 obstruction - pyloric

Due to

Due to

Other Conditions: Cachexia, anemia, dehydration (Include pregnancy within 6 months of death)

Date of operation

Major findings of operations:

As above 2 regional nodes of autopsy: metastases

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury E. L. Sargman

23. Signature E. L. Sargman M. D.

Address 19 CH Date signed 9/30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08642
441921BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08642
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Greta Stutzman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/13/35

8. AGE:

Years

Months

Days

If less than one day

5

7

17

hr

min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Robert Stutzman

13. Birthplace

Pa.

14. Maiden Name

Erdena Lynch

15. Birthplace

Pa.

16 (a) Informant

Records.

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

10/2/43

(month) (day) (year)

(c) Cemetery or crematory

Ladysburg Pa.

Location

Homer City Pa.

18 (a) Funeral director

John J. Mader

(b) Address

900 E. St. W.

19 (a)

OCT 1 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County

(c) City or town Homer City

(If outside city or town limits, write RURAL and give town)

(d) Street No. R.D.1.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1943, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1943, to Sept 30 1943, and that I last saw her alive on Sept. 30 1943.

Immediate cause of death Operation,
pneumonectomy

Due to Bronchiectasis

Due to Lobar Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-30-43

Major findings of operations: dense
adhesions. Multiple abscesses
of right lung.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address John Hopkins Hosp

Date signed 1/30/43

Approved by Howard J. Mader, M.D.

G 08643

MJ-83767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G 08643

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 110

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 220 S. Collington Ave.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Martin Dietrich

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 219-01-2213

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1869

8. AGE: Years Months Days If less than one day

74

8

20

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business F. A. Davis Co

12. Name Martin Dietrich

13. Birthplace Germany

14. Maiden Name Elizabeth Peiffer

15. Birthplace Germany

16 (a) Informant Mrs. Sadie Graefe

(b) Address 220 S. Collington Ave.

17 (a) Burial (b) Date thereof 10/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc

(b) Address North Ave. & Broadway

19 (a) (b)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1943, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1943 to 9-28 1943.

and that I last saw him alive on 9-28 1943.

Immediate cause of death

Bronchopneumonia
 Due to Hypertension
 Arteriosclerotic changes with
 Due to Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-24-43

Major findings of operation: Aneurysm of aorta

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald A. Webb

Address Baltimore City, Md

Date signed 9-29-43

Duration

1 wk

2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAILED - RESERVED FOR BINDING

OCT 1 - 1943

G 08644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08644

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *Don*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) *Ind* (b) County(c) *Baltimore* (If outside city or town limits, write RURAL and give town)(d) Street No. *1659 S. Baltimore* (If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME **ROBERT****MCNAMARA**

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. *216-20-6272*

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

*married*6 (b) Name of husband or wife *Margaret R. Irre**Fisher*6 (c) If alive, give age *34* years7. Birth date of deceased (mo., day, yr.) *April 22, 1898*

8. AGE:

Years

Months

Days

If less than one day

*45**45**7*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

fire-watcher

11. Industry or business

Gen'l Ship Repair Co.

12. Name

Michael McNamara

13. Birthplace

Ireland

14. Maiden Name

Catherine Scheemann

15. Birthplace

Ireland

16 (a) Informant

Margaret R. McNamara

(b) Address

Ireland

17 (a)

(Burial, cremation, or removal)

burial

(b) Date thereof

(month) (day) (year)

10/2/43

(c) Cemetery or crematory

Ba Hio. National

Location

Frederick Rd.

18 (a) Funeral director

M. W. E. Dippel's Sons

(b) Address

1000 Barclay & Ann Sts.

19 (a)

(Date of death)

*OCT 1 1943**Huntington, N.Y.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 29* 19*43* at *7:30* P.M.

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Valvular heart disease,**mitral insufficiency*

Due to

Rheumatic basis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature *H. Z. Wallenroth* M.D.

Medical Examiner.

Signed *9-30-43*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08645

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

NO

4. Sex

M

5. Color or race

W

3 (c) Social Security Account

No. 215-05-0894

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

(see Section 1) Jennie Sweeting

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Dec 25 1913

8. AGE: Years Months Days If less than one day

39 9 4 hr. min.

9. Birthplace

Balto

10. Usual Occupation

Laborer

11. Industry or business

Transportation

12. Name

Edward Sweeting

13. Birthplace

Unknown

14. Maiden Name

Elizabeth Bayer

15. Birthplace

Balto

16 (a) Informant

Jennie Sweeting

(b) Address

1065 Duncan St.

17 (a)

Burial

(b) Date thereof

10/12/43

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd.

18 (a) Funeral director

M. W. C. Dippel's Son

(b) Address

1065 Duncan St.

19 (a)

OCT 1 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(d) Street No. 1065 Duncan St.

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 29 1943

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1943 to Sept 29 1943.

and that I last saw him alive on Sept 29 1943.

Immediate cause of death

Encephalitis

Due to Pneumonia

Due to

Other Conditions developed

Endocarditis

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

J. C. Smith

Date signed

3-29-43

Duration

1 mo.

2 weeks

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117 a G 08646
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caroline & Oliver*

(c) Hospital or institution

St. Joseph's Hospital 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James O. York

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. *212-07-6967*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife *Maudie E. York*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan. 6th 1883*

8. AGE: Years Months Days If less than one day

60 8 24 hr. min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Laborer*

11. Industry or business *Cooperage*

12. Name *George York*

13. Birthplace *Baltimore Co. Md.*

14. Maiden Name *Elizabeth Carback*

15. Birthplace *Balto., Co. Md.*

16 (a) Informant *Mrs. James O. York*

(b) Address *Clark's Point Road Middle River*

17 (a) *Burial* (b) Date thereof *10/3/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Cheney Methodist*

Location *Chase, Md.*

18 (a) Funeral director *Passon Funeral Home*

(b) Address *7401 Belair Road*

19 *OCT 1 - 1943*

(Date and by whom signed)

William H. Fusting M.D.

St. Joseph's Inf.

9-30-43

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balt.*

(c) City or town *Middle River*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Clark's Point Road*

(If rural, give location)

(e) Citizen of foreign country? *No*

If yes, name country (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 30 1943 at 2³⁰ A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 29 1943* to *Sept. 30 1943*

and that I last saw him alive on *Sept. 30 1943*

Immediate cause of death: *Peritonitis*

Due to *Perforated Gastric Ulcer*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: *Same*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *William H. Fusting M.D.*

Address *St. Joseph's Inf.* Date signed *9-30-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING RESERVES FOR PRINTING

G 08647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08647

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Inkelaude & Rayner*

(c) Hospital or institution:

W. Balto Gen Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

5d.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5510 Gwynn Oak Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

HARVEY JOSEPHUS

Hutchins

3 (b) If veteran, name war

3 (c) Social Security Account

No. --

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

September 30, 1885

8. AGE: Years

Months

Days

If less than one day

58

0

0

hr.

min.

9. Birthplace

Mexico, Carroll Co.

(Town, county, and state)

10. Usual Occupation

Machinist

11. Industry or business

FATHER

12. Name *Samuel W. Hutchins*

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Emma Mathias

15. Birthplace

Tannery, Carroll Co.

16 (a) Informant

Mr. T. E. Etskorn

(b) Address

408 Alabama Rd.

17 (a) Burial

(b) Date thereof

10/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet Cem.

Location

Balto., Md.

18 (a) Funeral director

Wm. J. Tickner & Sons

(b) Address

Balto., Md.

19 (a)

OCT 1 - 1943

(Date received by registrar)

Harvey Hutchins

23. Signature

Isadore Shorofsky

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 30

1943, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 25* 1943, to *Sept 30* 1943, and that I last saw him alive on *Sept. 30* 1943

Immediate cause of death

Respiratory failure

Duration

Due to *cerebral hemorrhage*

Due to *hypertensive Cardio-vascular disease*

Other Conditions *Bronchopneumonia Terminal*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a G 08648
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2509 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARIETTA A. CHAPLINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife Charles L. Chapline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/1866

8. AGE: Years Months Days If less than one day

77

2

5

hr.

min.

9. Birthplace Poplar Springs, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Lloyd De Lander

13. Birthplace

14. Maiden Name

Julia Hyatt

15. Birthplace

Harper's Ferry, W. Va.

16 (a) Informant Mr. Charles Chapline

(b) Address 2509 W. North Ave.

17 (a) Burial (b) Date thereof 10/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto., Md.

OCT 1 - 1943

(b) Huntington Phillips, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 13, 1943, to Sep. 28, 1943.

and that I last saw him alive on Sep. 25, 1943.

Immediate cause of death Acute Renal Failure

Anterior Sclerosis of Kidneys

Acute Renal Failure on Stomach

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Herbert E. Ziff

Address 304 S. N. Ave. A

Date signed 9/28/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08649

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *36 Lloyd St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JOHN M. BURKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *m*

5. Color or race *w*

6 (a) Single, married, widowed, or divorced? *?*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 27-1897*

8. AGE:

Years

Months

Days

If less than one day

45

10

2

hr.

min.

9. Birthplace

Laurium, Mich

(Town, county, and state)

10. Usual Occupation

Unknown

11. Industry or business

FATHER
MOTHER

12. Name

John M. Orik

13. Birthplace

Germany

14. Maiden Name

Catherine Lehman

15. Birthplace

Germany

16 (a) Informant

Mrs. Marie Siegrist

(b) Address

201 S. Madison, Bay City, Mich

17 (a)

Removal

(b) Date thereof

Oct 1-48

(c) Cemetery or crematory

Buried

(d) Location

London P.R. Co.

18 (a) Funeral director

Mrs. L. Berger Jr

(b) Address

1612 Hollister St

19 (a)

1948

(b) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 29, 1948, at 3:15 PM*

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *W. L. Wallensten M.D.*

Date signed *9-30-48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08650

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **216 N. Carey St.**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) **19-2**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ma.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **216 N. Carey St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Louis Gross

3 (b) If veteran, name was 3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **Colored** 6 (a) Single, married, widowed, or divorced **Separated**

6 (b) Name of husband or wife **Maggie**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Oct. 17, 1876**

8. AGE: Years **66** Months **11** Days **11** If less than one day hr. min.

9. Birthplace **Calvert Co., Md.**
(Town, county, and state)

10. Usual Occupation **Laborer**

11. Industry or business

12. Name **George Gross**

13. Birthplace **Md.**

14. Maiden Name **Jane Wilson**

15. Birthplace **Md.**

16 (a) Informant **Annie Christina Gaynor**

(b) Address **307 N. Carrollton Ave.**

17 (a) **Burial** (b) Date thereof **10/3/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Carroll**

Location **Calvert Co., Md.**

18 (a) Funeral director **Elroy O. Wilson**

(b) Address **1000 B...**

OCT 1 - 1943

VB 184

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 28 1943 1:40 PM**

21. I certify that death occurred on the date above stated, and that I last saw the deceased on **Sept. 5, 1943** and that I last saw him alive on **Sept. 5, 1943**
Immediate cause of death **Tubercular pneumonia** Duration **3 days**

Due to **T.B. of intestines**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **NO**

Major findings of operations

of autopsy **NO**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

M. D.

G 08651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08651
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) DON

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 424 Caroline St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) FULL NAME

JESSIE JUTSON

DE

LOACH

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 15, 1917

8. AGE:

Years 26

Months 3

Days 11

If less than one day

hr.

min.

9. Birthplace

Louisville, Virginia

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

David D. Loach

13. Birthplace

Georgia

14. Maiden Name

Rosie Bache

15. Birthplace

Georgia

16 (a) Informant

David D. Loach

(b) Address

703 New Pittsburg Ave

17 (a)

Burial

(b) Date thereof

10-24-43

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Elmer D. Williams

(b) Address

1000 R. 1st Ave

19 (a)

OCT 1 - 1943

Elmer D. Williams, M.D.

VR 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1943, at 6 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Bullet wound of abdomen

Due to

Other Conditions

No

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-26-43 at 5:45 P.M.

(b) Where did injury occur? 1st of 1238 E.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?

(d) Means of injury Revolver - altercation

23. Signature H. A. Williams, M.D.

Date signed 9-26-43

G 08652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G 08652

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or day) 10-9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1113 E. Monument Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Helen Thompson

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

No

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

William P. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 21, 1856

8. AGE:

Years

Months

Days

If less than one day

87

5

29

hr.

min.

9. Birthplace

Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

14. Maiden Name

Betsy Citizen

15. Birthplace

Md.

16 (a) Informant

Hessie Hayes

(b) Address

305 N. Middle St.

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

E. J. Wilson

(b) Address

1000 E. Pratt St.

19 (a)

OCT 1 - 1943

(Date rec'd by registrar)

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-30-

1943, at 1:30 PM

21. I certify that I took charge of the remains described above, held an

autopsy, inspection or inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Howard J. Muldrew

M.D.

Date signed 9-30-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08653

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4512 Harford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 27-2

(e) Length of stay in Baltimore (yrs., mo., or days) 25 yrs

3 (a) FULL NAME

Adolph Luthy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Elenora Luthy

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

July 21st 1873

8. AGE:

Years

Months

Days

If less than one day

70

2

7

hr.

min.

9. Birthplace

Cleveland Ohio

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

August G. Luthy

13. Birthplace

Switzerland

14. Maiden Name

Mary M. Lehner

15. Birthplace

Switzerland

16 (a) Informant

Mrs Elenora Luthy

(b) Address

4513 Harford Ave

17 (a)

Burial

(b) Date thereof Oct 1st 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Befair Road

18 (a) Funeral director

Leo B. Cook

(b) Address

1701-03 1/2 Patterson Park Ave

19 (a)

OCT 1 - 1943

(Date recd. by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits write RURAL and give town)

(d) Street No. 4512 Harford Ave

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1943 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/1943 to 9/28/1943, and that I last saw him alive on 9-28-1943.

Immediate cause of death

Calculus of the gall bladder

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-28

Major findings of operation:

Calculus of the gall bladder

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. B. Cook

Address

307 Patterson Park Ave

Date signed 9/28/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08654

67604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08654

93d Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs & 2 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Anderson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25, 1868
8. AGE: Years 75 Months 0 Days 4 If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business
12. Name ?
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)
17 (a) Burial (b) Date thereof 10/1/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.
18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette St.

19 (a) OCT 1 - 1943 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/1943 at 4:20 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/1943 to 9/29/1943, and that I last saw him alive on 9/29/1943.
Immediate cause of death Cerebral thrombosis on coronary occlusion
Due to A.S. C.V. disease
Due to
Other Conditions Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy.

Duration
2
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. L. Saignes
Address B C H Date signed 9/30

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08655
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Lenox Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *5929 Old Pimlico Road*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

(Leroy Madison) Leroy Lee Madison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

13

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

School boy

11. Industry or business

FATHER

12. Name

Jack Madison

13. Birthplace

Va.

14. Maiden Name

Edna Johnson

15. Birthplace

Va.

16 (a) Informant

Jack Madison

(b) Address

5929 Old Pimlico Road

17 (a)

Burial

(b) Date thereof

Oct. 4, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or ossuary

Woodlawn

Location

Woodlawn Md.

18 (a) Funeral director

Chenault & Sonover

(b)

Chenault & Sonover

19 (a)

OCT 1 - 1943

(b)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-30-1943* at *9:30 P.M.*

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Rifle shot of abdomen
Due to involving liver & stomach

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *9-30-43* at *5:10 P.M.*

(b) Where did injury occur? *5905 Old Pimlico Road*

(c) Did injury occur at home, on farm, industrial place, in public

place? *Home* While at work? *No*

(d) Means of injury *Shooting, rifle*

23. Signature *Honard J. Walden* M.D.

Date signed *10-1-43* Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 08656	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH:			
(a) Baltimore City, Maryland			
(b) Street address 420 E. 26 th St.			
(c) Hospital or institution:			
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12			
(e) Length of stay in Baltimore (yrs., mos., or days)			
2. USUAL RESIDENCE OF DECEASED:			
(a) State Md.			
(b) County			
(c) City or town Baltimore			
(d) Street No. 426 E. 26 th St.			
(e) Citizen of foreign country (Yes or No)			
3 (a) FULL NAME Michael O. Neill			
3 (b) If veteran, name war			
3 (c) Social Security Account No.			
4. Sex Male			
5. Color or race White			
6 (a) Single, married, widowed, or divorced Widowed			
6 (b) Name of husband or wife Mary Ann			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) Aug 26-1868			
8. AGE: Years 74 Months 1 Days 13 hr. min.			
9. Birthplace Ireland			
10. Usual Occupation Bartender			
11. Industry or business Retired			
12. Name Michael O. Neill			
13. Birthplace Ireland			
14. Maiden Name Mary Smith			
15. Birthplace Ireland			
16 (a) Informant Mary O. Neill			
(b) Address 420 E. 26 th St.			
17 (a) Burial (b) Date thereof Dec 2-43			
(c) Cemetery or crematory Holy Redeemer			
Location Belair Rd.			
18 (a) Funeral director John A. Moran			
(b) Address 4201 Greenmount Ave			
19 (a) (b)			
20. DATE OF DEATH Sept 29 th 1943 at 5:45 P.M.			
21. I certify that death occurred on the date above stated; that I attended deceased from March 8 th 1943 to Sept 28 th 1943, and that I last saw him alive on Sept 28 th 1943.			
Immediate cause of death Coronary Isthmus			
Due to			
Due to			
Other Conditions			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operation:			
of autopsy:			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?			
(Specify type of place)			
(e) Means of injury			
23. Signature J. J. Sankar			
Address 100 N. Millman Date signed 10/1/43			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08657
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 415 N. Chappel St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

30 2 21 hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name George Washington

13. Birthplace Md.

14. Maiden Name Emma Smith

15. Birthplace Md.

16 (a) Informant Russell Davis

(b) Address 415 N. Chappel St.

17 (a) Burial (b) Date of death Oct. 3, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Ceph.

Location G. A. County Md.

18 (a) Funeral director Mrs. Robert G. Elliott, Dgt.

(b) Address 1129 N. Caroline St.

19 (a) (b) Date rec'd by William M. R.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 415 N. Chappel St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943, at 10 W. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1943, to Sept. 29 1943, and that I last saw her alive on Sept. 29 1943.

Immediate cause of death Pulmonary Tuberculosis.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lucius Snyder M. D.

Address 634 G. Westminster Date signed 9/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 1 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08658
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color of race

6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1942, to Sept 29 1942, and that I last saw him alive on Sept 27 1942.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

OCT 1 1943

08659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08659

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 Street No. 112 E. Center Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

MOSE JENNINGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 24, 1870

8. AGE: Years

72

78

Months

89

Days

5

If less than one day

hr.

min.

9. Birthplace

Annapolis, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name Moses Jennings, Sr.13. Birthplace Annapolis, Md.14. Maiden Name Harriet Brown15. Birthplace Annapolis, Md.

16 (a) Informant

Daniel T. Brown

b) Address

Annapolis, Md.

17 (a)

Burial

b) Date thereof

Oct 4, 1949

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Mary's Cemetery

Location

Annapolis, Md.

18 (a) Funeral director

John W. Taylor

b) Address

Annapolis, Md.

19 (a)

OCT 1 - 1949

(b) Harriet Brown, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 29, 1943 at 7:30 P. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature J. W. Allen M.D.

Date signed

2-30-43

G 08660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08660

Registered No.

92 b

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1050 Vine St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME Lillian Pealo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 7, 1906

8. AGE:

Years

Months

Days

If less than one day

37

3

21

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

domestic

11. Industry or business

FATHER
MOTHER

12. Name Daniel Peal

13. Birthplace Balt. Md.

14. Maiden Name Mary Augustus

15. Birthplace Balt. Md.

16 (a) Informant

Mary Pealo

(b) Address

1050 Vine St.

17 (a)

Burial

(b) Date thereof

Oct 1, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

18 (a) Funeral director

Mrs. Peter R. Williams

(b) Address

322 N. Charles St.

19 (a)

OCT 1 - 1943

H. M. Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1050 Vine St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1943, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1943, to Sept. 28 1943 and that I last saw him alive on Sept. 27 1943.

Immediate cause of death

Mitral Stenosis

Due to

Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. Waller Shering

Address

201 N. Carey St.

Date signed

10/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08661
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

674 N. Guilmore St.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 31, 1867

8. AGE: Years

76

Months

Days

If less than one day

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

Lucile Hyman

(b) Address

647 N. Guilmore St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Sept. 21-43

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore City

18 (a) Funeral director

Geo. S. Nelson

(b) Address

1303 President St.

Huntington Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1943, at 1:00 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to this death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Graham

M.D.

Date signed

Sept 29, 1943

OCT 1 - 1943

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08662		BALTIMORE CITY HEALTH DEPARTMENT		G 08662	
CERTIFICATE OF DEATH		131a		Registered No.	
1. PLACE OF DEATH:				2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland				(a) State <u>md</u> (b) County	
(b) Street address <u>139 S. Augusta Ave</u>				(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution:				(d) Street No. <u>139 S. Augusta Ave</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>20</u>				(e) Citizen of foreign country? (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days)				If yes, name country	
3 (a) FULL NAME <u>William F. Bahr</u>				MEDICAL CERTIFICATION	
3 (b) If veteran, name war		3 (c) Social Security Account No.		20. DATE OF DEATH <u>Sept 29 1943</u> at <u>2:20 P.M.</u>	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced <u>Widowed</u>		21. I certify that death occurred on the date above stated; that I attended deceased from <u>Nov. 10, 1942</u> to <u>Sept 29, 1943</u> , and that I last saw him alive on <u>Sept 28, 1943</u> .	
6 (b) Name of husband or wife <u>Caroline Bahr</u>				Immediate cause of death <u>Pneumonia</u>	
6 (c) If alive, give age years				<u>Pulmonary Edema</u>	
7. Birth date of deceased (mo., day, yr.) <u>May 6, 1858</u>				Due to <u>Hypertensive Cardiovascular Disease</u>	
8. AGE: Years <u>85</u>	Months <u>4</u>	Days <u>23</u>	If less than one day hr. min.	Due to <u>Chronic Nephritis</u>	
9. Birthplace <u>Germany</u> (Town, county, and state)				<u>Arteriosclerosis</u>	
10. Usual Occupation <u>Retired Express business</u>				Other Conditions	
11. Industry or business				(Include pregnancy within 3 months of death)	
12. Name <u>Joseph Bahr</u>				Date of operation	
13. Birthplace <u>Germany</u>				Major findings of operation:	
14. Maiden Name <u>Ernestine Strasche</u>				of autopsy:	
15. Birthplace <u>Germany</u>				22. If death was due to external causes, fill in the following:	
16 (a) Informant <u>Mrs Amelia Rauch</u>				(a) Accident, suicide, or homicide	
16 (b) Address <u>139 S. Augusta Ave</u>				(b) Date of occurrence at <u>M</u>	
17 (a) <u>Burial</u> (b) Date thereof <u>Oct 2, 1943</u> (Burial, cremation, or removal) (month) (day) (year)				(c) Where did injury occur? (City or town) (County) (State)	
(c) Cemetery or crematory <u>Holy Redeemer</u>				(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?	
18 (a) Funeral director <u>Leonard J. Rauch</u>				(e) Means of injury	
18 (b) Address <u>5305 1st St. N. Washington, D.C.</u>				Signature <u>H. J. Bayler</u>	
19 (a) <u>OCT 1 - 1943</u>				Address <u>1600 W. 1st Ave</u> Date signed <u>9/29/43</u>	
VS 150					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108 G 08663
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Lexington Sts*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Lawrence J. Zimlan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 1, 1888

8. AGE: Years

54

Months

55

Days

30

If less than one day

hr.

min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

Hotel Steward

11. Industry or business

FATHER

12. Name

Michael J. Zimlan

13. Birthplace

Balto., Md.

14. Maiden Name

Delia Enright

15. Birthplace

Ireland

16 (a) Informant

Lawrence J. Zimlan

(b) Address

Zone

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10-4-43

(c) Cemetery or crematory

Cathedral

Location

Balto.

18 (a) Funeral director

Leonard J. Hughes

(b) Address

5305 - 4th St. Baltimore, Md.

19 (a)

OCT 1 - 1943

William M. Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Balto.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Zone 2603*

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 30, 1943* at *6 P M*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/26 1943* to *9/30 1943*, and that I last saw him alive on *9/30 1943*.

Immediate cause of death

Congestive heart failure & embolism

Due to

Pneumococcus pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Robert B. Turner*

Address *Mercy Hosp.* Date signed *9/30/43*

Duration

7

PHYSICIAN

Underline the cause to which death should be charged statistically.

Y8 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a G 08665
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 324 S. Monroe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 324 S. Monroe St.

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3 (a) FULL NAME

Mrs. Alice W. Willingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Henfield S. Willingham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 - 1856

8. AGE: Years Months Days If less than one day

87

5

13

hr.

min.

9. Birthplace Baltimore Md

10. Usual Occupation

Retired

11. Industry or business

Housewife

FATHER

12. Name

Richard Alexander

13. Birthplace

Baltimore, Maryland

MOTHER

14. Maiden Name

Zeppora Foxwell

15. Birthplace

Baltimore, Maryland

16 (a) Informant Howard Charles Willingham

(b) Address 122 South Calver St

17 (a) Burial

(b) Date thereof 10-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Int. Olivet

Location

Baltimore

18 (a) Funeral director George L. Schwab

(b) Address 4101 Eubank Ave.

19 OCT 1 - 1943

(b)

Willingham

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1943 at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1943 to Sept 28 1943 and that I last saw him alive on Sept 27 1943

Immediate cause of death

Pulmonary embolism

Duration

48 hrs

Due to Fractured left hip

3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following 20/3

(a) Accident, suicide, or homicide Acc

(b) Date of occurrence 9/24/43 at 9:00 AM

(c) Where did injury occur? 324 S. Monroe St
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)

(e) Means of injury slipped & fell in kitchen

23. Signature Albert Kermish

Address 1934 Williams Ave Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

For R.R. Graham - approved by Howard J. Willingham, MD

G 08666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PRUITT X ✓ G 08666

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Sydenham Hospital 9-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William Clarence Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 - 1940

8. AGE:

Years

Months

Days

If less than one day

3

7

5

hr.

min.

9. Birthplace

Wash. D.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

William A. Pruitt

13. Birthplace

Aderson Co., S.C.

14. Maiden Name

Ottie Millie Ashby

15. Birthplace

Abbeville, S.C.

16 (a) Informant

Hospital Records

(b) Address

17 (a) Removal

(b) Date thereof 10-1-43

(c) Cemetery or crematory

(month) (day) (year)

(d) Cemetery or crematory

Hyattsville

Location

Hyattsville, Md.

18 (a) Funeral director

Francis L. Lusk, Son

(b) Address

Hyattsville, Md.

19 (a)

(Date rec'd by registrar)

Oct 1 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Montgomery

(c) City or town

Landover

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1943, to Sept. 29 1943, and that I last saw him alive on Sept. 29 1943.

Immediate cause of death

Respiratory failure

Due to

Laryngeal edema
diphtheria

Due to

Other Conditions

Bronchopneumonia

(Include pregnancy within 5 months of death)

Major findings:

Of operations

Of autopsy

Laryngeal edema
Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Margaret M. Smith

Address

Sydenham Hosp.

Date signed

9/30/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08667
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 3101 St. Paul street
 (c) Hospital or institution: ----
 (d) Length of stay in hospital or inst. (yrs., mos., or days) --12
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3101 St. Paul
 (If give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country

3 (a) FULL NAME

ALBERT B. KRIES

3 (b) If veteran, name war

No ~~218-01-7852~~

3 (c) Social Security Account

No. 218-01-7852

4. Sex
Male5. Color or race
white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Spies Kries

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1893

8. AGE Years Months Days If less than one day
49 11 4 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Elks Club

12. Name Michael A. Kries
13. Birthplace Baltimore, Md.14. Maiden Name Louise Schultz
15. Birthplace Baltimore, Md.16 (a) Informant Mrs. Alice Spies Kries
(b) Address 3101 St. Paul street17 (a) Burial (b) Date thereof 10/2/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral18 (a) Funeral Home
(b) Address 118 N. Mt. Royal Ave.19 (a) Date of death OCT 1 - 1943
(b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1943 to 9/29 1943
and that I last saw him alive on 9/29 1943

Immediate cause of death

Lobar pneumonia
& cardiac failure

Due to

Due to

Other Conditions Chronic kidney
dysfunction B.C.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature John T. Mason
Address 804 Cathedral Date signed 9/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186 G 08668
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Walters & Caton Aves.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *19 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mrs. Belle Shaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-19-55

8. AGE:

Years

Months

Days

If less than one day

88

8

11

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER
FATHER

12. Name

Edw. G. Russell

13. Birthplace

W.B.

14. Maiden Name

Mary Colson

15. Birthplace

Md.

16 (a) Informant

Little Sisters of the Poor

(b) Address

1200 Valley St.

17 (a)

Burial

(b) Date thereof

Oct. 2, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore

18 (a) Funeral director

Rita Woodfield

(b) Address

914 Greenmount Ave

19

OCT 2 1943

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Eager & Valley Sts

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 30, 1943, 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from *9/11 1943* to *9/30 1943*, and that I last saw her alive on *9/30 1943*.

Immediate cause of death

Cardiac failure

Due to

Arteriosclerotic heart disease

Due to

Other Conditions

Fracture of left hip

(Indicate pregnancy within 4 months of death)

Date of operation

9/18/43

Major findings of operations

Apprehension of R.A. wall by Splint

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: *10/1*

(a) Accident, suicide, or homicide *Accident*

(b) Date of occurrence *Sept. 13* at *9:00 AM*

(c) Where did injury occur? *Little Sisters of the Poor*

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *at about home* While at work? *No*

(Specify type of place)

(e) Means of injury

Fall to floor while sitting

23. Signature

Howard W. Shaffer

Address

St. Agnes Hospital

Date signed

9/29/43

Robert Lee Graham

M.D.

Oct. 1 1943

Huntington Williams, M.D.
Approved:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08670
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 686 Sarah Ann St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

3 (a) FULL NAME

Rev - Nick Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Essie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-1894

8. AGE: Years Months Days If less than one day

48

10

19

hr.

min.

9. Birthplace

Oglethorpe Ga

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

unknown

13. Birthplace

14. Maiden Name

Hattie?

15. Birthplace

Ga.

16 (a) Informant

Essie Watkins

(b) Address

686 Sarah Ann St

17 (a) Shipped

(b) Date thereof 10-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Brooklyn Cemetery

Location

Athens, Ga.

18 (a) Funeral director

William A. Jackson

(b) Address

966 Perry Ave

19 (a) Date rec'd by registrar

OCT 1 1943

(b) Registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 686 Sarah Ann St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1943 at 7:05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 27, 1943 to Sept 29, 1943, and that I last saw him alive on Sept 29, 1943.

Immediate cause of death

Asphyxia, pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH102 G 08671
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Martha Kent

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female Black

married

6 (b) Name of husband or wife

Harold

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

11-1-1900

8. AGE:

Years

Months

Days

If less than one day

42

10

28

hr.

min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Henry Harmon

13. Birthplace

?

14. Maiden Name

?

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Suicidal

(b) Date thereof

Oct. 3, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

Mrs. George M. Stollan

(b) Address

1631 Druid Hill Ave.

19 (a)

OCT 1-1943

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

2111 Druid Hill Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 29, 1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1943, to Sept. 29, 1943, and that I last saw her alive on Sept. 29, 1943.

Immediate cause of death

Cardiac failure

Uremia

Duration

24 hrs.

Due to

Malignant hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul O. Clithfield

Address

Johns Hopkins Hosp.

Date signed

7/10/43

G 08672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08672
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 429 Moore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Same md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 429 Moore St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Elizabeth Johnson

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

Phillip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1878

8. AGE: Years 65 Months 5 Days 20 hr. min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Corbett Duckett

13. Birthplace

Maryland

14. Maiden Name

Olivia

15. Birthplace

Maryland

16 (a) Informant

Phillip Johnson

(b) Address

429 Moore St.

17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof Oct. 4, 1943
(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

Baltimore, Md.

18 (a) Funeral director

Mrs. George W. Holland

(b) Address

1631 David Hill Ave.

19 (a) OCT 1 - 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1943, at 9:05 A.M.

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Chronic myocardial
degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed Sept. 29, 1943 Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH163H G 08673
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1519 Montmor Court

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1519 Montmor Court

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Nancy Cole Hailey

3 (b) If veteran, name war

(c) Social Security Account

No. none

4. Sex

F

5. Color or race

C.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/19/1918

8. AGE:

Years

Months

Days

If less than one day

25

1

10

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

MOTHER

12. Name

Percy B. Cole

13. Birthplace

Birmingham, Ala.

14. Maiden Name

Eva Valentine

15. Birthplace

Baltimore, Md.

16 (a) Informant

Eva Cole

(b) Address

274 St. 140th

17 (a)

Burial

(b) Date thereof

Oct. 4, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

St. Ann's

Location

Annapolis, Md.

18 (a) Funeral director

The George H. Holland

(b) Address

1000 Swift Hill Ave.

19 (a)

(b)

(Date rec'd by registrar)

Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 29

1943, at 2:55 AM

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Asphyxiation

due to ~~car~~ illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Sept. 29 1943 1:20 AM

(b) Where did injury occur?

1519 Montmor Court

(c) Did injury occur at home, on farm, industrial place, in public

place? home

While at work? no

(d) Means of injury

Turned on burner of gas stove

23. Signature

Robert Lee Bratton

M.D.

Date signed

Sept. 20 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH181 G 08674
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Barnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1020 Linden Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Walter Fields

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

colored

6 (a) Single, married, widowed, or
divorced

married

6 (b) Name of husband or wife

Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 19088. AGE: Years 35 Months 4 Days 26
If less than one day hr. min.9. Birthplace Birmingham, Ala.
(City, town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

13. Birthplace

Alabama

14. Maiden Name

Olive

15. Birthplace

Alabama

16 (a) Informant Benjamin Mortu(b) Address 2210 Madison Ave.17 (a) Burial (b) Date thereof Oct. 1, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Birmingham, Ala.18 (a) Funeral director Mrs. George W. Holland(b) Address 1601 Quail Hill Ave.19 (a) OCT 1 - 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1943 at 10:20 AM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Toxemia due
to 2nd degree burns.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury Sept. 28, 1943 5:50 P.M.(b) Where did injury occur? Brown Copper & Brass Co.(c) Did injury occur at home, on farm, industrial place, in public
place? Industrial While at work? Yes(d) Means of injury Explosion23. Signature Robert L. Graham

Medical Examiner

Date signed Sept. 29, 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1420 Orleans Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

James Arthur Gilchrist

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1943

8. AGE:

Years

Months

Days

If less than one day

7

hr.

min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Charles Johnson

13. Birthplace

Unknown

14. Maiden Name

Ada Gilchrist

15. Birthplace

Maryland

16 (a) Informant

Hospital Records

(b) Address

Johns Hopkins Hospital

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL OCT 1 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

OCT 1 1943 Huntington Williams, M.D.
(Date for'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1943. at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept. 5 1943. to Sept. 12 1943
and that I last saw him alive on Sept. 12 1943.

Immediate cause of death

Aspiration pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Johns Hopkins Hospital signed 9-16-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08676
50 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 1 - 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30

1943

at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1943 to Sept 30 1943 and that I last saw her alive on 9/30/43 19

Immediate cause of death

Respiratory failure

Due to

Generalized metastasis

Due to

Carcinoma of breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Cancer of breast 2 yrs.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edward Shorephy MD

Address

West Baltimore

Date signed 9/30/43

G 08677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131

G 08677

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3714 Hillsdale Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3714 Hillsdale Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John William Jones

3 (b) If veteran, name war

No

3 (c) Social Security Account

No No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Margaret A. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 8, 1853

8. AGE:

Years

Months

Days

If less than one day

90

7

21

hr.

min.

9. Birthplace St. Mary's County, Md.

(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

12. Name William Jones

13. Birthplace St. Mary's County, Md.

14. Maiden Name Mary Ellen Stone

15. Birthplace St. Mary's County, Md.

16 (a) Informant Mr. Ernest E. Jones

(b) Address 3300 Oakfield Ave.

17 (a) Burial (b) Date thereof Oct. 2, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium Woodlawn Cemetery

Location

Woodlawn, Md.

18 (a) Funeral director

(b) Address 4010 Liberty Heights Ave.

OCT 1 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1943 at 8.05P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1943 to Sept. 27 1943, and that I last saw him alive on Sept. 23 1943.

Immediate cause of death

1) - Broncho.

Due to - Pneumonia

Due to - Fracture of Rt. Hip.

Other Conditions - Arterio-sclerotic

Cardio - Vascular Disease.

(Include pregnancy within 3 months of death)

Date of operation - None

Major findings of operation:

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Earl L. Chambers M. D.

Address 4108 Liberty Hgts Ave Date signed

Duration

7 days

5 yrs.

6 3 yrs.

- 10 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08678
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (year, month, or days)

(e) Length of stay in Baltimore (year, month, or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Forest Hill
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Francis Clayton Thompson III

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex
male5. Color or race
white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
— 9 10 hr. min.9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Frank C. Thompson, Jr.

13. Birthplace Indiana

14. Maiden Name Lena May Miller

15. Birthplace Virginia

16 (a) Informant Hospital Admission Record.

(b) Address

17 (a) Burial (b) Date thereof Oct 4-43
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Woodlawn
Location Blenheim Va.

18 (a) Funeral director Spring Bay

(b) Address 5005 Park Heights

Date filed by registrar OCT 1-1943 (b) Registrar William H. Hester

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1943 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1943 to Sept. 30 1943, and that I last saw him alive on Sept. 30 1943.

Immediate cause of death Cardio-resp. failure

Due to A. pneumonia

Due to

Other Conditions Congenital heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Power Jr.
Address Union Mem Hosp Date signed 9/1/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08679

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163H

G 08679

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 210 S. Harmon St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2(e) Length of stay in Baltimore (yrs., mos., or days) (LIFE)

3 (a) FULL NAME

HARRY W. ROACH

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

(M)6 (b) Name of husband or wife Lida R. Roach6 (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) July 6 - 1877

8. AGE: Years Months Days If less than one day

66225

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Mr. H. Roach13. Birthplace Pa14. Maiden Name Katherine M. Bartley15. Birthplace Mass16 (a) Informant Lida R. Roach(b) Address 210 S. Harmon St.17 (a) Burial (b) Date thereof 10/2/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London ParkLocation Baltimore, Md.18 (a) Funeral director F. B. WIPPERTSON(b) Address 1800 W. Baltimore St.19 (a) Oct 1 - 1945 (b) Registrar Huntington Williams, M.D.20. DATE OF DEATH Sept. 29 1945, at 8 AM

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 210 S. Harmon St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945, at 8 AM

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Asphyxiationdue to illuminating gas

Due to

Other Conditions Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury Sept. 29 1945 7 AM(b) Where did injury occur? 210 S. Harmon St.

(c) Did injury occur at home, on farm, industrial place, in public

place? home While at work? no(d) Means of injury Turned on furnace of gas stove23. Signature Robert Lee Graham M.D.Date signed Sept. 29 1945

OCT 1 - 1945

VS 151

G 08680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08680

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color of skin

6 (a) Single, married, widowed,
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) ~~entombment~~

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Coryman Schuman

Angina Pectoris

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

1913

1913

1913

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08681

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Howard & Madison*

(c) Hospital or institution:

Maryland General Hosp(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Harry Schmidt

3 (b) If veteran, name war

None

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Mattie H. Schmidt*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *2-5-1877*

8. AGE: Years

66

Months

7

Days

27

If less than one day

*hr. min.*9. Birthplace *Baltimore Md*

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

Construction Man

12. Name

Albert Schmidt

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Md

16 (a) Informant

Mattie H. Schmidt

(b) Address

*1918-Land St*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Oct. 4, 43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Balto

18 (a) Funeral director

Wm Cook Inc.

(b) Address

1217 St Paul St.

19 (a) (Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County

(c) City or town

Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1918 Land St.*

(If rural give location)

(e) Citizen of foreign country? *no*

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*9/30*19*43*at *8:45*

A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *9/27* 19*43* to *9/30* 19*43* and that I last saw him alive on *9/30* 19*43*

Immediate cause of death

acute heart failure

Due to

Due to

Other Conditions

Voluntarily

(Include pregnancy within 3 months of death)

Date of operation

9/27/43

Major findings of operation:

*Voluntarily*of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

Signature

Thomas F. Lusk, M.D.

Address

*Md. Gen. Hosp.*Date signed *9/30/43*

Duration

1 day(?)

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 2 - 1943

G 08682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08682

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *606 St. Paul St*
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) *11-2*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *606 St. Paul St*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mayme Cathell McCrisken

3 (b) If veteran, name war

*None*3 (c) Social Security Account
No. *None*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 10, 1883*8. AGE: Years Months Days If less than one day
60 6 19 hr. min.9. Birthplace *Baltimore, Md*
Town, county, and state10. Usual Occupation *Housewife*11. Industry or business *Own Home*12. Name *William Cathell*13. Birthplace *Md.*14. Maiden Name *Lecunia*

15. Birthplace

16 (a) Informant *Mr M. J. McCrisken*(b) Address *606 St. Paul St*17 (a) *Cremation* (b) Date thereof *10/2/43*
(Month) (day) (year)(c) Cemetery or crematory *Greenmount*
Location *Baltimore, Md.*18 (a) Funeral director *William Cook Inc*(b) Address *1217 St. Paul St*19 (a) *OCT 2 - 1943* *Huntington* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/29/43* at *12:20 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *July 27, 1943* to *Sept 29, 1943*, and that I last saw *her* alive on *9/28/1943*.

Immediate cause of death

*Cardio Respiratory Failure*Due to *Arteriosclerotic Cardiovascular disease*Due to *Cor*Other Conditions *Coronary Vascular Disease*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature *John L. Davis, Jr.*Address *Mercy Hospital* Date signed *9/29/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

8683

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08683

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City ~~Marlborough~~ Apts.
(b) Street address 1701 Eutaw Place.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Ab't 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Eutaw Place.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

MAX MYERS

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Florence R. Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1851.

8. AGE: Years Months Days If less than one day
92 8 9 hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

12. Name Joseph Myers,

13. Birthplace Phila. Pa.

14. Maiden Name Unknown,

15. Birthplace Phila. Pa.

16 (a) Informant Mrs. F. R. Myers,

(b) Address Marlborough Apts.

17 (a) Burial (b) Date thereof 10/3/43.

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Balto. Md.

18 (a) Funeral director David Sanderson

(b) Address 1902 Eutaw Place

OCT 2 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1st. 1943, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1943 to Oct. 1 - 1943, and that I last saw him alive on Oct. 1 - 1943.

Immediate cause of death

Coronary Thrombosis
Due to Advanced arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis Sgamb

Address 1700 Eutaw Place Date signed 10/1/43

Duration

years
3

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08684
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
3727 Foster Ave

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3727 Foster Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Herman Otto Haberkorn

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Rose Haberkorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1882

8. AGE: Years 61 Months 7 Days 5 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Freight Conductor

11. Industry or business Penn R R

12. Name George N Haberkorn

13. Birthplace Germany

14. Maiden Name Caroline Schrul

15. Birthplace Germany

16 (a) Informant Mrs Rose Haberkorn

(b) Address 201 N Ellwood Ave

17 (a) Burial (b) Date thereof Oct 4/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Colgate Balto Co Md

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Orleans St

19 (a) (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1943 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death

Acute Cardiac dilatation

Due to

Atrophic Lepetic Corbosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 35 S. Lombard Date signed 10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 2 - 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08685

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
2004 Jefferson

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Ida C Geiwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Hans Geiwitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1874

8. AGE: Years Months Days If less than one day
69 11 hr. min.

9. Birthplace Penna

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Oliver Smith

13. Birthplace Penna

14. Maiden Name Don't know

15. Birthplace Penna

16 (a) Informant William H Geiwitz

(b) Address 229 S Clinton St

17 (a) Burial (b) Date thereof Oct 4/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location Baltimore Md
Ulrich Funeral Home

18 (a) Funeral director 2008 Orleans St

(b) Address

19 (a) OCT 2 - 1943

Huntington Williams, M.D. 5304 Baltimore

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2004 Jefferson

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1943, 5:30 P M

21. I certify that death occurred on the date above stated that I attended deceased from Jan 29 1943 to Feb 30 1943 and that I last saw him alive on 9-30 1943

Immediate cause of death

Coronary Arteriosclerosis

Due to Coronary Thrombosis 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. W. Kirk Date signed 10/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08686

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Julius H. Hinkle Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mon

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County

(c) City or town: Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 411 N. Ann St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Wieria B. Diggs

3 (b) If veteran, name war

3 (c) Social Security Account

No. 424-146726

4. Sex

Male

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Dec 6-1920

8. AGE: Years Months Days If less than one day

22 9 23 hr. min.

9. Birthplace Dothan Ala

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edgar Diggs

13. Birthplace Ala

14. Maiden Name Minnie Praxton

15. Birthplace Ala

16 (a) Informant Mrs Bessie Lawrence

(b) Address 11 Suitman St. Newark N.J.

17 (a) Burial (b) Date thereof Oct 3-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Dothan, Alabama

18 (a) Funeral director Sam H. Chace, Jr.

(b) Address 638 N. Guilford St.

19 (a) Date signed by

(b) Signature

Date signed Sept 29, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1943, at 1:55 M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wound

of chest

Due to

Other Conditions

(Include pregnancy within 9 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following:

(a) Date of injury Sept 29, 1943 1:40 M

(b) Where did injury occur? 700 block N. Spring St.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public place While at work? No

(d) Means of injury Stabbing

23. Signature Robert L. Watson M.D.

Date signed Sept 29, 1943 Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2545 W. Baltimore St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2545 W. Baltimore St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME

Miss Alice Marie Randel

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-03-6394

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15th 1920

8. AGE: Years Months Days If less than one day

23

8

15

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

Printing

12. Name

Emanuel E. Randel

13. Birthplace

York, Pa.

14. Maiden Name

Lottie A. Bains

15. Birthplace

Carroll Co. Md.

16 (a) Informant Mr. Emanuel E. Randel

(b) Address 2545 W. Balto. St.

17 (a) Burial (b) Date thereof 10/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location

Balto. Md.

18 (a) Funeral director

Geo. Weber & Son

(b) Address 2503 Edmondson Ave

19 (a) 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 1st 1943. at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Sept 10 1943, and that I last saw her alive on Sept. 1 1943.

Immediate cause of death

Acute disseminated
Lupus Erythematosus.

Due to

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 8 E. Edmondson Ave Date signed 10-1-43

Duration

6 months.

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 2 1943

Registrar

Ellis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 EG 08688 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 519 Richwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 519 Richwood Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

HENRY LAY MURPHY

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1863

8. AGE:

Years

Months

Days

If less than one day

80

0

20

hr.

min.

9. Birthplace

Little Rock, Ark.

(Town, county, and state)

10. Usual Occupation Linotype Operator

11. Industry or business

Retired

FATHER
MOTHER

12. Name

Reginald H. Murphy

13. Birthplace

Ireland

14. Maiden Name

Eliza Simmons

15. Birthplace

La.

16 (a) Informant Miss Margaret C. Murphy

(b) Address 519 Richwood Ave

17 (a) Burial (b) Date thereof Oct. 4, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Prospect Hill

Location

Towson, Md.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) OCT 2 - 1943

VR 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1943 at 9⁴⁵ P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1940 to Oct. 1, 1943, and that I last saw him alive on Oct. 1, 1943.

Immediate cause of death

Cerebral Hemorrhage.

Duration

1 day

Due to Atherosclerosis

Due to Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

Signature Carl H. Benson M.D.

Address 5111 York Rd Date Oct 1, 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08689

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): 21 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Baltimore
(c) City or town: Baltimore
(d) Street No.: 4209 Eastview Road
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Wilson Rowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1943

8. AGE: Years 0 Months 0 Days 21 If less than one day hr. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

infant

12. Name

J. Wilson Rowe

13. Birthplace

Maryland

14. Maiden Name

Nancy Dylancy

15. Birthplace

Maryland

16 (a) Informant

Medical chart

(b) Address

17 (a)

Burial

(b) Date thereof 10/2/43
(month) (day) (year)

(c) Cemetery or crematory

Harold Ridge

Location

Pikesville, Md.

18 (a) Funeral director

Wm. J. Tuckman & Sons

(b) Address

Balto., Md.

19 (a)

OCT 8 - 1943

Wm. J. Tuckman & Sons

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1943, at 6:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30, 1943, to Oct. 1, 1943, and that I last saw him alive on Oct. 1, 1943.

Immediate cause of death: Cordis - resp. failure

Due to: Pneumonia consolidation of right lung

Due to:

Other Conditions: Suppurated whole right lung cavity
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same as above.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: James N. McCosh

Address: Union Memorial Hospital Date signed: Oct 2, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08690

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08690

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital 15-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

3 (a) FULL NAME

Charles Edward Craig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1877

8. AGE:

Years 66

Months 4

Days 8

If less than one day

hr.

min.

9. Birthplace

Maryland

10. Usual Occupation

Bank Teller

11. Industry or business

FATHER

12. Name

Oliver B. Craig

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Katherine Franke

15. Birthplace

Maryland

16 (a) Informant

Charles Edward Craig

(b) Address

3313 Alto Rd. Balto Md.

17 (a)

Burial

(b) Date thereof

10/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Greenmount Cem.

Location

Balto, Md.

18 (a) Funeral director

Wm. J. Tichenor & Sons

(b) Address

Balto, Md.

OCT 2 1943

(Date and year)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Maryland

(b) County

(c) City or town

Baltimore - 6.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3313 Alto Rd.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 1 1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1943 to Oct 1 1943. and that I last saw him alive on Oct 1 1943.

Immediate cause of death

Cardiorespiratory failure

Duration

Due to obstruction, intestinal breakdown of anastomosis resection

2 days

Due to Adenocarcinoma of sigmoid

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: 9-20-43 & 9-30-43

Major findings of operation: 1. Adenocarcinoma of sigmoid 2. as above.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Huntington Jr

M. D.

Address 332 E. University Pkwy Date signed Oct 1 - 43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

H. M. Williams M.D.

G 08691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08691

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address Calvert & 33rd St.

(c) Hospital or institution:

Union Memorial(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Hugh Muir

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Katherine A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1870

8. AGE: Years Months Days If less than one day

73222

hr.

min.

9. Birthplace Scotland

(Town, county, and state)

10. Usual Occupation Retired R. R. Conductor11. Industry or business P. R. R.12. Name William Montgomery Muir13. Birthplace Scotland14. Maiden Name Grace Bunting15. Birthplace Scotland16 (a) Informant Mrs. Katherine A. Muir(b) Address 500 E. 35th St.17 (a) Burial (b) Date thereof 10/2/43
(Burial, cremation, or exposure) (month) (day) (year)(c) Cemetery or crematory Druid Ridge Cem.Location Pikesville, Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.

19 (a)

OCT 8 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 500 E. 35th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1943 at 3:35 P.M.21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtainedby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Howard J. McAldeie M.D.Date signed 9-30-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08693
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1313 N. Broadway

(c) Hospital or institution:

Pennsylvan. Med. Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Carroll E. Snyder Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

6 4 26 hr. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name: Carroll E. Snyder

13. Birthplace: Md.

MOTHER

14. Maiden Name: Margaret Carlton

15. Birthplace: Md.

16 (a) Informant: Mrs. M. Snyder

(b) Address: 1313 N. Broadway

17 (a) Burial (b) Date thereof: Oct 4, 1943

(c) Cemetery or crematory: Holy Redeemer

Location: Belpair Road

18 (a) Funeral director: Leo S. Hook

(b) Address: 701-03 N. Pat. Pichler

19 (a) OCT 2, 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County

(c) City or town: Balto.

(If outside city or town limits, write RURAL, and give town)

(d) Street No: 1313 N. Broadway

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1943, 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death: Sarcoma (S)

Physician

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature: Henry Muswid

Address: Sinai Hosp Date signed: 9-31-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08694

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

183 G 08694
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address: *Baltimore, Maryland*
(c) Hospital or institution: *Balto. City Harbor*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *8*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1603 N. Patt. Park Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Christian Schlerf

3 (b) If veteran, name war

3 (c) Social Security Account
No. *272-12-7396*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

40

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Christian Schlerf

13. Birthplace

md.

14. Maiden Name

Amanda Ewell

15. Birthplace

md.

16 (a) Informant

Pearl Schlerf

(b) Address

1603 N. Patt. Park Ave.

17 (a)

Burial

(b) Date thereof

10-2-43

(c) Cemetery or crematory

Balto. Cem.

Location

E. North ave Ext

18 (a) Funeral director

Leo S. Crook

(b) Address

1701-03 N. Patt. Park Ave

19 (a)

OCT 2 - 1943

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH *9-27-1943* at *1 P.* M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Found Drowned.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

- (a) Date of injury *9-27-43* *7:30 A.*
(b) Where did injury occur? *near Pier #3, Pratt St.*
(c) Did injury occur at home, on farm, industrial place, in public place? *Public Place* While at work? *no?*
(d) Means of injury *Found Drowned.*

23. Signature

Howard J. Walden

Medical Examiner.

M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 08695
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2242 McHenry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2242 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

NICHOLAS O. WEBER.

3 (b) If veteran, name war

NONE.

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Hesterude Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 - 1897

8. AGE: Years Months Days less than one day
66 0 18 hr. min.

9. Birthplace Md. Dorough - Md.

(Town, county, and state)

10. Usual Occupation

Farming

11. Industry or business

12. Name Adams Weber

13. Birthplace Penna.

14. Maiden Name Sophie Cwirings

15. Birthplace Cwirings Mills - Md.

16 (a) Informant Mrs. Hesterude Weber

(b) Address 2242 McHenry St.

17 (a) Burial (b) Date thereof Oct. 4 - 43.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Charles J. Schurab

(b) Address 505 N. Madison St.

19 (a) Dr. Livingston Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 - 1943 at 3:40 P.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1943 to 9/30 1943, and that I last saw him alive on 9/13 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Bayless

Address 1600 W. ... Date signed 10/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

10-10-43

G 08696

BALTIMORE CITY HEALTH DEPARTMENT

G 08696

T.M

83776

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6 N. Mount St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Addie Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV, 28, 1876

8. AGE:

Years

Months

Days

If less than one day

66

11/0

2

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Parnell Miles

13. Birthplace Maryland

MOTHER

14. Maiden Name Marie Dennis

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 10-3-43

(Burial, cremation, or reburial)

(month) (day) (year)

(c) Cemetery or crematorium Mt. Calvary

Location Ark. Co. Md.

18 (a) Funeral director Mrs. G. H. Hunsley

19 (a) (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12-1943 to 9-30-1943 and that I last saw her alive on 9-30-1943

Immediate cause of death

Pulmonary Embolism?
Carcinoma of Rectum

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-16-43

Major findings of operations: Carcinoma of Rectum

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Address Baltimore City, Md. Date signed 9-30-43

Duration

4 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08697

08697

MJ-84041

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1127 Madison Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Marie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1905

8. AGE: Years

37

Months

10

Days

20

If less than one day

hr.

min.

9. Birthplace South Carolina

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Rance Smith

13. Birthplace South Carolina

14. Maiden Name Selly Smith

15. Birthplace South Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10-3-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Grey St. Baptist

18 (a) Funeral director

(b) Address

578 W. 1st St. Baltimore, Md.

19 (a) (b)

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29-43 1943 at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1943 to 9/29 1943 and that I last saw her alive on 9/29 1943

Immediate cause of death

Pulmonary Tuberculosis

Duration

1 yr.?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

E. J. Sargison

Address

BCH

Date signed

7/30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATION RESERVED FOR BINDING

08698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13b

08698

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 148 d

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1428 McCulloh St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Gertrude Pratt

81335

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

female

5. Color or race

black

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1911

8. AGE:

Years

Months

Days

If less than one day

31

11

20

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

housewife

11. Industry or business

FATHER

12. Name

James Smith

13. Birthplace

Md.

MOTHER

14. Maiden Name

Annie Gale

15. Birthplace

Md.

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a)

Burial

(b) Date thereof

10-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem

Location

Baltimore, Md.

18 (a) Funeral director

Wm. A. Hensley

(b) Address

578 W. 17th St.

19 (a)

10-1-43

(b)

H. H. Hensley

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1943 at 10:00A

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Sept. 7~~ 7/1 1943, to Sept. 30 1943, and that I last saw him alive on Sept. 30 1943.

Immediate cause of death

Tuberculous meningitis
PULMONARY tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Sigmund

BCH

Date signed 10/1

G 08699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08699
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dg

(e) Length of stay in Baltimore (yrs., mos., or days) 1 dg

3 (a) FULL NAME

Baby Boy Zuna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1943

8. AGE: Years Months Days If less than one day

2

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Zuna

13. Birthplace Pa

MOTHER

14. Maiden Name Catherine Schultz

15. Birthplace md

16 (a) Informant Parents

(b) Address 7004 Belchere Rd

17 (a) Burial (b) Date thereof 11/2/43

(c) Cemetery or crematory St. Stanislaus

Location Balto, md

18 (a) Funeral director John J. Connelly

(b) Address 110 Eastern Ave.

19 (a) OCT 2 - 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore Dundalk

(If outside city or town limits, write RURAL, and give town)

(d) Street No 7004 Belchere Road

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1943 to 10-1-1943, and that I last saw him alive on 10-1-1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

1 dg

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles B. McDonald

M. D.

Date signed 10-1-43

G 08700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08700

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2215 Prentiss Place

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2215 Prentiss Place

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JAMES JOHN MATULA, SR.

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife Antonia (nee Hladky)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/28/75

8. AGE: Years

68 yrs.

Months

Days

2

If less than one day

hr.

min.

9. Birthplace Czechoslovakia

(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Michael Matula

13. Birthplace Czech.

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Anna Saffa (daughter)

(b) Address 2215 Prentiss Place

17 (a) Burial (b) Date thereof 10/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) OCT 2 - 1943

(Date of registration)

H. J. Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1943 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sep 30 1943.

and that I last saw him alive on 9/28 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Anteroseptal Myocardial Infarction

Due to

Vascular Disease

Other Conditions

Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph S. Blum, M.D.

Address 1206 E. Prentiss St Date signed 10/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATION RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08701

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1419 Mosher St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Sallie Mae Motley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Fe

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July, 1943

8. AGE: Years

Months

Days

If less than one day

3

hr.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Emmett Motley

13. Birthplace

Virginia

14. Maiden Name

Louise Spoker

15. Birthplace

Va

16 (a) Informant

Emmett Motley

(b) Address

1419 Mosher St.

17 (a) Burial

(b) Date thereof

10/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Int Auburn

Location

18 (a) Funeral director

Edo. S. Nelson

(b) Address

1303 Dressman

OCT 2 - 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Salto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1419 Mosher St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 1943 at 8:45 AM

21. I certify that death occurred on the date above stated that I attended deceased from Sept 29 1943 to Oct 1 1943 and that I last saw her alive on Oct 1 1943

Immediate cause of death

Acute gastro

enteritis, non-specific, moderate

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Ralph W. Glick

Address

426 N. G. Ave.

Date signed 10/2/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08702
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3203 E. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 E. PRATT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mabel S. Moore

3 (b) If veteran, name war
no

3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced
Widow

6 (b) Name of husband or wife Joseph H. Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1864

8. AGE: Years 78 Months 10 Days 27
If less than one day
hr. min.

9. Birthplace Reckland, Delaware
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

12. Name Allen M. Lane

13. Birthplace Maryland

14. Maiden Name Leah Lutton

15. Birthplace DELAWARE

16 (a) Informant ERNEST S. MOORE

(b) Address 1300 N. ALEXINGTON

17 (a) BURIAL (b) Date thereof OCT 3 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CHERRY HILL ME
Location CHERRY HILL MD

18 (a) Funeral director WENDELL J. DIPPEL

(b) Address 312 S. HIGHLAND AVE

OCT 2 1943 (b) Harriet Williams

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1943 to 9/30 1943 and that I last saw him alive on 9/29 1943.

Immediate cause of death Cerebral hemorrhage Duration

Due to Anterior-Schism

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harriet Williams
Address 3215 Avenue Date signed 9/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08703

CRANFORD
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93-7

Registered No. 08703

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Calveringham

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1292 Riverside Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife late Ada Cranford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 1862

8. AGE: Years

80

Months

11

Days

If less than one day

hr.

min.

9. Birthplace Calvert Co. Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Unknown

13. Birthplace Calvert Co. Md.

14. Maiden Name Unknown

15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs. Ada Bennett

(b) Address 5825 Frederick Rd.

17 (a) Burial (b) Date thereof 10/3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Emanuel

Location Plum Point Calvert Co. Md.

18 (a) Funeral director Harry H. Wicks

(b) Address 4101 6th Avenue N.E.

OCT 2 1943

Wm. H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1943, at 4:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1942, to Oct 1 1943, and that I last saw him alive on Sept 28 1943.

Immediate cause of death

chronic myocarditis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Williams

Address 7324 Reservoir Rd. Date signed 10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08704

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4718 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louis C. Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Rosa S. Mueller

7. Birth date of deceased (mo., day, yr.)

Nov. 22, 1864

8. AGE:

Years

78

Months

10

Days

8

If less than one day

hr. min.

9. Birthplace

Balts. Md.

10. Usual Occupation

Plumbing Contractor

11. Industry or business

Retired

12. Name

Mueller

13. Birthplace

Germany

14. Maiden Name

Germany

15. Birthplace

Mrs. Rosa S. Mueller

16 (a) Informant

(b) Address 4718 Edmondson Ave

17 (a) Burial (b) Date thereof Oct. 4/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ludon Park

Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 E Edmondson Ave

20. DATE OF DEATH Sept. 30, 1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sept 30, 1943 and that I last saw him alive on Sept 30, 1943.

Immediate cause of death Crown thrombosis

& Chronic myocarditis

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature Dr. E. Wells

Address 4718 Edmondson Ave

Date signed 10-1-43

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 mo.

14 mos.

14 mos.

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08705

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 900 E. Biddle St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Antoinette Apicella

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1870

8. AGE: Years Months Days

73

3

7

If less than one day

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Maffei

13. Birthplace

Italy

14. Maiden Name

Filomena

15. Birthplace

Italy

16 (a) Informant

Husband

(b) Address

900 E. Biddle

17 (a) Burial

(b) Date thereof Oct 4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location Belair Road

18 (a) Funeral director

Frank V. Pipitone

(b) Address

2818 E. Balto. St.

19 (a) (Date rec'd by registrar)

(b) William Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 900 E. Biddle St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1943, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1942, to Oct. 1, 1943, and that I last saw her alive on Oct. 30, 1943.

Immediate cause of death

Carcinoma (Breast)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1940

Major findings of operation: Carcinoma

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Eugene P. Passagno

Address 514 Murray Pl Date signed 10/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS OCT 2-1943

G 08706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08706
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hosp. 207

(d) Length of stay in hospital or inst. (yrs., mos., or days) 204

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 208 S. Helen St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Switzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1879

8. AGE:

Years

Months

Days

If less than one day

64

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Lithographer

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

John E. Lewis

(b) Address

4219 Westview Rd.

17 (a)

Burial

(b) Date thereof

10-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Landon Park

Location

Baltimore, Md.

18 (a) Funeral director

Leonard J. Rush

(b) Address

5305 Harford Rd.

(Date rec'd by registrar)

(b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1943, at 12:30 AM

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hyper tension
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert Lee Graham M.D.

Medical Examiner.

Date signed Sept. 29, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08707
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Redwood & Greene*
(c) Hospital or institution: *Community Hospital*
(d) Length of stay in hospital or inst. (yr. or days) *21 days*
(e) Length of stay in Baltimore (yr. or days) *1 year*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *BALTO.*
(c) City or town *BALTO. MD*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3330 Woodland Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rosetta Baldridge
3 (b) If veteran, name war
3 (c) Social Security Account No. *None*

4. Sex *F* 5. Color or race *W.* 6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband *Miles S. Baldridge*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 6, 1900*

8. AGE: Years *43* Months *6* Days *28* If less than one day hr. min. *25*

9. Birthplace *Indiana*
(Town, county, and state)

10. Usual Occupation *House wife*

11. Industry or business

12. Name *Walter Weldon*

13. Birthplace *Indiana*

14. Maiden Name *Ida Ferguson*

15. Birthplace *Indiana*

16 (a) Informant *Miles S. Baldridge*

(b) Address *3330 Woodland Ave*

17 (a) *Burial* (b) Date thereof *Oct 6, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Coldwater*

Location *Coldwater, Michigan*

18 (a) Funeral director *Harry H. Witke*

(b) Address *401 Edmonson Ave*

Atty. Gen. Williams, MD

OCT 2 - 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 1, 1943, at 8:30 P. M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 10, 1943*, to *Oct 1, 1943*, and that I last saw him alive on *Oct 1, 1943*.

Immediate cause of death

Obstetrical

Due to *Peritonitis*

Due to *Hypernephroma*

Other Conditions *Acute ulcer*

(Include pregnancy within 3 months of death)

Date of operation *9/10/43 appendectomy*

Major findings of operation: *Peritonitis*

of autopsy: *Peritonitis, sublytic ulcers*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *M. V. Palmer*

Address *Community Hosp.* Date signed *10/2/43*

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08708

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Calvert + Gardenway
(c) Hospital or institution: Murray Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 da
(e) Length of stay in Baltimore (yrs., mos., or days) 26 da

2 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race white 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/43

8. AGE: Years Months Days 2 6 7 If less than one day hr. min.

9. Birthplace Murray Hospital, Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Guy Deamer

13. Birthplace Pa

14. Maiden Name Aggie Goss

15. Birthplace Pa

16 (a) Informant Hospit. Ruskord

(b) Address

17 (a) Burial (b) Date thereof 10 4 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Peter's Church
Location Balto. Md.

18 (a) Funeral director George A. Farley

(b) Address Fulton St Fayette

OCT 2 - 1943

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Calvert + Gardenway St
(If rural, give location)
(e) Citizen of foreign country? No
If yes, name country

Deamer 83770

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1943 at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1943 to 9/28 1943, and that I last saw him alive on 9/28 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph B. Shurba M. D.

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDS RESERVED FOR BIDDING

G 08709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92b

G 08709

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Wilkins and Catow Ave*

(c) Hospital or institution:

St. Agnes

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 Days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Catonville*

(c) City or town *Catonville*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mae Uppey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age *5/1/1891*

7. Birth date of deceased (mo., day, yr.) *9-20-43*

8. AGE: Years Months Days If less than one day

52 84 29 hr. min.

9. Birthplace *Baltimore MD*
(City, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

Bank

12. Name *T. Uppey (dec'd)*

13. Birthplace *Maryland*

14. Maiden Name *Loach (dec'd)*

15. Birthplace *Maryland*

16 (a) Informant *Arthur Uppey*

(b) Address *63 Glenwood Ave*

17 (a) *Burial* (b) Date thereof *10/4/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium *St Paul Cemetery*

Location *Arcaadia Md.*

18 (a) Funeral director *John S. May 7/43*

(b) Address *Catonville*

(c) *St. Agnes Hospital*

OCT 3 - 1943

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 30 1943 at 6:40 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 28 1943* to *Sept 30 1943*, and that I last saw her alive on *Sept 30 1943*.

Immediate cause of death *Valvular Heart Disease, mitral stenosis on a Rheumatic basis.*

Due to *Multiple Embolism*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury *Chloroform poisoning*

23. Signature *E. Uppey*

Address *St. Agnes Hosp.* Date signed *9/30/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107 Registered No. G 08710

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33rd + Calvert Sts.

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

10 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town

Baltimore Parkville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7905 Harford Rd.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Never given a name - Baby Boy Jumper

(Jerry L. Jumper)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1943

8. AGE:

Years

Months

Days

If less than one day

0

0

9

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Aaron Jumper

MOTHER

13. Birthplace Pa.

14. Maiden Name Irma Myers

15. Birthplace Pa.

16 (a) Informant

(b) Address

Med chart

17 (a) Removal

(b) Date thereof

10/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Westminster Cem.

Location

Carlisle, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT. 2

19 43. 05:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20, 1943, to Oct. 2, 1943.

and that I last saw him alive on Oct. 2, 1943.

Immediate cause of death

Cardio-respiratory failure

Due to

Broncho-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James H. McGee Jr.

M. D.

Address Union Memorial Hospital

Date signed 10-2-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08711
MJ-81378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55e G 08711
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. 4 mos., 24 days
(e) Length of stay in Baltimore 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 S. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Sophie Cohen

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1894

8. AGE:

Years

Months

Days

If less than one day

49

8

4

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Aided by DPW

11. Industry or business

FATHER
MOTHER

12. Name David Cohen (D)

13. Birthplace Russia

14. Maiden Name Annie Fishman

15. Birthplace Russia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial

(b) Date thereof October 3, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cem

Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

OCT 3 - 1943
(Date rec'd by registrar)

Donald Williams, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1943 at 7:5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1943 to 10-1 1943, and that I last saw him alive on 10-1 1943.

Immediate cause of death

Abdominal Carcinomatosis
Due to site of origin undetermined

Duration

5 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald B. Webb M. D.
Address Baltimore City Hosp Date signed 10-2-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. County age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED FOR BIDDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.J. (b) County

(c) City or town BRIDGETON N.J.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 83 WOODLAND DRIVE
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip ROYNER

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

MALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Rebecca

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE: Years

65

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

12. Name DAVID ROYNER

13. Birthplace RUSSIA

14. Maiden Name ?

15. Birthplace RUSSIA

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 3/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bridgeton N.J.

Location

18 (a) Funeral director Tol Levinson & Bros

(b) Address 1124-26 W. North ave

19 OCT 3 - 1943 H. H. Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1943 at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1943 to 10/2 1943, and that I last saw him alive on 10/2 1943.

Immediate cause of death

Myocardial Infarction

Due to Coronary Thrombosis

Due to Arterio-Sclerotic Heart Disease

Other Conditions Diabetes mellitus

Ruptured Intervertebral Disc

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. H. Williams, M.D.

Address John Hopkins Hospital

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c 08713
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N. North Avenue
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. North Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Irene Tittmer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Andrew J. Tittmer
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) Aug. 21, 1899
8. AGE: Years 44 Months 1 Days 10 If less than one day hr. min.
9. Birthplace Oxford, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Jamilton E. Belderson
13. Birthplace Va.
MOTHER
14. Maiden Name Daisy Richardson
15. Birthplace Oxford, Md.

16 (a) Informant Mr. Andrew J. Tittmer
(b) Address 228 N. North Ave.
17 (a) Burial (b) Date thereof 1/4/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Oxford, Md.
18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place
OCT 3 - 1943 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 10/1/1943 at 11:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1941 to Oct 1943, and that I last saw her alive on Oct 1, 1943.
Immediate cause of death Pulmonary Edema
Due to Cardiac Insufficiency 1 mo
Cardiac Hypertrophy 4-5 years
Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thelma Cooper
Address 2107 Park Ave. Date signed 10/2/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 180

When completing this certificate, please write the causes of death clearly and legibly.

08714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186 08714
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Bethlehem - Fairfield Shipyards
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 Patapasco ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Mitchell
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Ethel W. Mitchell
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr) Aug 17, 1898
8. AGE: Years Months Days Less than one day
45 1 15 hr. min.
9. Birthplace Bedford Co. PA.
(Town, county, and state)
10. Usual Occupation LABOR.
11. Industry or business SHIPYARDS.

FATHER
12. Name HENRY MITCHELL
13. Birthplace Bedford Co. PA.
MOTHER
14. Maiden Name MARY M. MITCHELL
15. Birthplace Bedford Co. PA.

16 (a) Informant Ethel W. Mitchell.
(b) Address New Paris, Bed, Co, Pa.
17 (a) Burial (b) Date thereof Oct, 5, 43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Paris, Location Bedford Co, PA.
18 (a) Funeral director Vernon B. Heisel
(b) Address Alton Bant, Pa.
OCT 3 - 1943 (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH October 2 1943, at 2 P M
21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were: IMMEDIATE CAUSE OF DEATH Fracture of skull
Due to
Other Conditions
(include pregnancy within 3 months of death)
22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 2nd 1943 2 P M.
(b) Where did injury occur? Bethlehem Fairfield Shipyards
(c) Did injury occur at home, on farm, industrial place, or public place? Industrial While at work? Yes
(d) Means of injury Fall off scaffold
23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed October 2nd 1943 (over)

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08715
1246 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 10/4/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1943, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24, 1943, to October 1, 1943, and that I last saw him alive on 10/1/43

Immediate cause of death

Cardio respiration failure

Due to profuse toxicemia due to liver damage. in Due to a basilar pontal cerebellum

Other Conditions Hypertension Cardiovascular disease (Include pregnancy within 3 months of death)

Date of operation September 24, 1943

Major findings of operation: Cerebral

liver, spleen, mesentery, lungs

Other findings: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 10/1/43

Duration

PHYSICIAN

Underline the cause to which path should be charged statistically.

G 08716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08716

242 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Wilkins and Caton Ave*
 (c) Hospital or institution: *St. Agnes*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *2 hrs*
 (e) Length of stay in Baltimore (yrs., mos., or days) *23 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *City*
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3907 Bateman Avenue*
 (If rural, give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name *Thomas Newman*13. Birthplace *Maryland*14. Maiden Name *Jellie (DeLamarter)*15. Birthplace *Maryland*

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

Oct. 6 1943

(c) Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18 (a) Funeral director

(b) Address

*George F. Guthrie**1230 Hartford Ave**OCT 3 - 1943*

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 2 1943 at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 2 1943* to *Oct 2 1943* and that I last saw him alive on *Oct 2 1943*

Immediate cause of death

Generalized septicemia
 Due to *Multiple renal and pulmonary abscesses*
 Due to *Coccidioides immitis*
 Other Conditions - *Brain abscess*

Duration

PHYSICIAN

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: *Multiple abscesses*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

*Alfred J. Garman*Address *St. Agnes Hospital* Date signed *9/8/43**H. Williams, M.D.*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 08717
52a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 622 S. DEAN ST.
(c) Hospital or institution:(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days LIFE

3 (a) FULL NAME

TERESA C. KOERNER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife THOMAS H. KOERNER

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. SEPT. 11 1905

8. AGE: Years Months Days If less than one day

38

0

29

hr.

min

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name MAX STOCK

13. Birthplace GERMANY

14. Maiden Name UNKNOWN

15. Birthplace N.Y.

16 (a) Informant THOMAS H. KOERNER (HUS)

(b) Address 622 S. DEAN ST.

17 (a) BURIAL (b) Date thereof OCT. 4/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) OCT 3 1943 by registrar *William H. Williams*

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 622 S. DEAN ST.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH OCT. 1 19 43 at 5/30M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Oct. 1 19 43, and that I last saw her alive on 9/29 19 43.

Immediate cause of death

Sarcoma left kidney with metastasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 637 S. Conkling St. Date signed 10/11/43

Duration

About 6 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08718

186 a Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME

MARY C. HEALY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.)

7/6/88

8. AGE:

Years

Months

Days

Less than one day

55

2 10

7 30

hr.

min.

9. Birthplace

Balto.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name

Martin Healy

13. Birthplace

Ireland

14. Maiden Name

Jennie Conway

15. Birthplace

Balto Md.

16 (a) Informant

Mrs. Charles Bulzer

(b) Address

207 Dickman St.

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore Md.

18 (a) Funeral director

Flynn & Flynn

(b) Address

1426 Light St.

19 (a)

Oct 3 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Dickman.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/43 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1943 to 10/2 1943 and that I last saw him alive on 10/2 1943.

Immediate cause of death

Skull Fracture, etc.
Due to Fall down steps.
Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 6, 1943 at 12:15 A.M.
(c) Where did injury occur? 207 Dickman St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall down steps

23. Signature

Paul A. Gubatz

Address 213 Light St. Date signed 10-2-43

Approved:

Robert L. Graham M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08719

BALTIMORE CITY HEALTH DEPARTMENT

G 08719

T.N

83147

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 month
& 19 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 217 Myrtle Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Millie Williams

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

Female

C

6 (a) Single, married, widowed, or
divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1901

8. AGE: Years Months Days If less than one day
42 3 1 hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Joseph Skinner (D)

13. Birthplace N.C

14. Maiden Name Sarah Johnson (D)

15. Birthplace N.C

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (records)

17 (a) Burial (b) Date thereof Oct 4, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs. Kate B. Williams

Address 217 Myrtle Ave

19 (a) Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1943 at 4 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8-10 1943 to 9-29 1943,
and that I last saw her alive on 9-29 1943.

Immediate cause of death

Bronchopneumonia

Due to

large ulcer Lt arm

Due to

on torn gold seam

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald M. Webb

Address Baltimore City Hosp Date signed 9-30-43

Duration

2 days

months

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 08720

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08720
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1939

8. AGE: Years Months Days If less than one day
4 7 5 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Ellsworth Randall, Jr.

13. Birthplace Balto. Md.

14. Maiden Name Annie May Powell

15. Birthplace Jackson, D.C.

16 (a) Informant Annie May Randall

(b) Address 520 N. Guilmer St.

17 (a) Burial (b) Date thereof Oct. 3, 1948

(c) Cemetery or crematory Mt. Calvary Cmi

Location #1

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 3229 N. Schermer St.

OCT 3 1948 Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 520 N. Guilmer St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1943, at 10:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to deep laceration of left axilla.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 29, 1943 M.

(b) Where did injury occur? 520 N. Guilmer St.

(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No

Means of injury Fall down steps

23. Signature Robert L. Graham, M.D.

Medical Examiner.

Date signed Sept. 29, 1943

G 08721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08721

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

1943

19 (b) Signature of registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.U.R. and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/29

1943, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5:55 1943 to September 27, 1943, and that I last saw her alive on 9/20/43 19

Immediate cause of death

Acute myocardial infarction

Due to

Interstital nephritis

Due to

Hypertension

Other Conditions

(Include pregnancies within 3 months of death)

Date of operation

none

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. T. Williams

Address

2222 Marlinton

M. D.

Date signed

9/29/43

G 08722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08722

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

CERTIFICATE OF DEATH

G 08723

170c

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~State~~ ^{City}

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4317 Harford Road

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George W.

(Vogt) VOIGT

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1943, at 9 A.M.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mary Voigt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 3, 1970

8. AGE:

Years

Months

Days

If less than one day

73

6

28

hr.

min.

9. Birthplace

Baltimore City

(Town, county, and state)

10. Usual Occupation

Machinist

11. Industry or business

Canning Implements

FATHER

12. Name

August T. Voigt

13. Birthplace

Germany

14. Maiden Name

Anna Meisel

15. Birthplace

Germany

16 (a) Informant

Mary Voigt

(b) Address

4317 Harford Rd.

17 (a)

Burial

(b) Date thereof

10/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Olivet

Location

Balto. City

18 (a) Funeral director

G. Vernon Lemmon

(b) Address

4611 Park Heights

OCT 8 - 1943

(Date rec'd by registrar)

H. W. Williams

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of pelvis
Compound comminuted fracture
of left tibia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept. 30 1943

27/2

(b) Where did injury occur? Harford Rd + Overland Ave

(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? no

(d) Means of injury Struck by auto

23. Signature Robert Lee Graham M.D.

Date signed October 1st 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08724

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 410 S Regester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S Regester St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank S. Liwinski

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 71 Months Days If less than one day hr. min.

9. Birthplace Poland (Give county, and state)

10. Usual Occupation Car Cleaner

11. Industry or business B & P

12. Name Ignace Liwinski

13. Birthplace Poland

14. Maiden Name ?

15. Birthplace Poland

16 (a) Informant Margaret

(b) Address 410 S Regester St

17 (a) Burial (b) Date thereof Oct 4/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Baltimore

18 (a) Funeral director Fred W. Oszagowski

(b) Address 1930 Eastern Ave

OCT 3 - 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1943, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943, to Oct 1 1943, and that I last saw him alive on Oct 1 1943.

Immediate cause of death Cancer of Throat + esophagus +

Due to

Due to

Other Conditions Bronchopneumonia 3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leo L. Kulacki

Address 126 S. Patterson St Date signed Oct 4/43

Leo L. KULACKI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08725

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 203 S Ann St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John Bednarczyk

3 (b) If veteran, name war

No.

3 (c) Social Security Account

No. 218 03 0136

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

51

If less than one day

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name John Bednarczyk

13. Birthplace Poland

14. Maiden Name Rozalia Kulisza

15. Birthplace Poland

16 (a) Informant Stella Bednarczyk

(b) Address 203 S. Ann St.

17 (a) Burial (b) Date thereof Oct. 5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Dzayuski

Address 1930 Eastern Ave.

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 203 S. Ann St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1943, at 12 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Oct 1 1943, and that I last saw him alive on Oct 1 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2128 W. North Ave. Date signed 10/2/43

Duration

1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08726

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive and 31st St.
- (c) Hospital or institution: US Marine Hospital, Baltimore, Md.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
- (e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 715 S. Bond Street
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

NELS HILGAG HANSON

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. **217 14 0485**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 6, 1895**

8. AGE: Years Months Days If less than one day

48**4****25**

hr.

min.

9. Birthplace **Lund, Sweden**

(Town, county, and state)

10. Usual Occupation **Asst. Engineer**

11. Industry or business

12. Name **Oscar Hansen**13. Birthplace **Sweden**14. Maiden Name **Anna Lewau**15. Birthplace **Sweden**16 (a) Informant **Records-US Marine Hospital**(b) Address **Baltimore, Md.**17 (a) **Burial** (b) Date thereof **Oct 4/43**
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Sacred Mt of Mary**
Location **Baltimore**18 (a) Funeral director **Fred W. Ozyguter**(b) Address **930 Eastern Ave**(c) Address **1315 Huntington Rd**(d) Address **1315 Huntington Rd**(e) Address **1315 Huntington Rd**(f) Address **1315 Huntington Rd**(g) Address **1315 Huntington Rd**(h) Address **1315 Huntington Rd**(i) Address **1315 Huntington Rd**(j) Address **1315 Huntington Rd**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 1, 1943, at 11:55 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 1, 1943** to **Oct. 1, 1943**, and that I last saw him alive on **Oct. 1, 1943**.

Immediate cause of death

Ruptured esophageal varix

Duration

Unk.

Due to **Advanced atrophic cirrhosis of liver** **Unk.**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: **None**of autopsy: **As above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature **US Bean / [Signature]**Address **US Marine Hospital** Date signed **10/2/43**
Baltimore, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08727

75839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

96 ✓ G 08727
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 1 mo. 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Herman Russell Camper

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex
Male

5. Color or race
Colored

6 (a) Single, married, widowed, or
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1916

8. AGE: Years Months Days If less than one day
27 8 25 2 1/2 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Medford Richard Camper

13. Birthplace Maryland

14. Maiden Name Margaret

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Oct. 3, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1671 Union Hill Ave.

OCT 4 - 1943

(Date rec'd by Registrar)

VB 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1943 19 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 19 to 19
and that I last saw him alive on 19

Immediate cause of death Military Tuberculosis
Potter Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul M. C. H.

Address B. C. H.

Date signed 9-30-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

08728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1630 ✓ G 08728
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1802 Bolton St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Fannie A. Massey

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 12, 1874

8. AGE:

Years

Months

Days

If less than one day

68

9

21

hr.

min.

9. Birthplace

Bluem Anne Co. Md.

(Town, county, and state)

10. Usual Occupation

Companion

11. Industry or business

FATHER
MOTHER

12. Name

Josiah Massey

13. Birthplace

Kent Co. Maryland

14. Maiden Name

Annie Evans

15. Birthplace

Bluem Anne Co. Md.

16 (a) Informant

Mrs Grace Zisch

(b) Address

300A East Community Parkway

17 (a)

Burial

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Chesley

Location

Chesleytown Md.

18 (a) Funeral director

Myron L. Williams

(b) Address

Chesleytown Maryland

19

OCT 4 - 1943

(Date rec'd by registrar)

Huntington Hillman, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3rd 1943, at 9 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☒homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bichloride of

mercury poisoning

Due to

Other Conditions

Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept 22 1943 M.

(b) Where did injury occur? 1802 Bolton St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Swallowed Bichloride tablet

23. Signature Robert Lee Graham M.D.

Date signed Oct. 3rd 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G 08729

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or institution:

ST JOSEPH HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) Md.

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1617 N. Gay St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Camillo Baucia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife late GIUSEPPINA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1863

8. AGE: Years 80 Months 5 Days 28 If less than one day hr. min.

9. Birthplace Italy

(Town, county, and state)

10. Usual Occupation Polish

11. Industry or business

12. Name Giovanni Baucia

13. Birthplace Italy

14. Maiden Name Maria Marcellina

15. Birthplace Italy

16 (a) Informant GIOVANNI BAUCIA - SON.

(b) Address 1617 N GAY ST.

17 (a) Burial (b) Date thereof Oct 4-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Con

Location Belgar Rd.

18 (a) Funeral director Frank Della Nore

(b) Address 52 N. Macley St.

OCT 4 - 1943 (Huntington Williams, M.D.)

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 1943, at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1943, to 10-2 1943, and that I last saw him alive on 9-1 1943.

Immediate cause of death Cerebral Hem. - aneurysm

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature Nathan E. Bherdi

Address St. Joseph's Hospital Date signed 10-2-43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08730

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **1 day**
(e) Length of stay in Baltimore (yrs., mos., or days) **?**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County **?**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2406 Barclay St**
(If rural, give location)
(e) Citizen of foreign country? **?** (Yes or No)
If yes, name country **?**

3 (a) FULL NAME

Anthony De Medio Demedio

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. **216-09-8190**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife **Josephine De Medio**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Mar 22, 1889**

8. AGE:

Years

Months

Days

If less than one day

54

6

10

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Shipper

11. Industry or business **Bethlehem Fairfield Shipyard**

FATHER
MOTHER

12. Name

Buster DeMedio

13. Birthplace

Italy

14. Maiden Name

Marie ?

15. Birthplace

Italy

16 (a) Informant **Baltimore City Hospitals**

(b) Address **4940 Eastern Ave (Records)**

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Oct. 5th/43**

(month) (day) (year)

(c) Cemetery or crematory **Holy Redeemer**

Location **Balair Rd. Baltimore Md.**

18 (a) Funeral director **Frank Della Noce**

(b) Address **52 N. Morley St.**

19 (a) **OCT 4 - 1943**

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **10/2 1943 at 4:15 A**

21. I certify that death occurred on the date above stated; that I attended deceased from **10/1 1943 to 10/2 1943** and that I last saw him alive on **10/2 1943**.

Immediate cause of death

**Coronary card failure
& peripheral collapse**

Due to

acute Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Serpinin

Address

13 CH

Date signed **10/2**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68731

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8300 ✓ G 08731
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1362 N. Calhoun St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

15

(e) Length of stay in Baltimore (yrs., mos., or days)

50 yrs

3 (a) FULL NAME

Julia Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. ☒ F

5. Color or race

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

1871

8. AGE: Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace

Prince George Co. Md

10. Usual Occupation

11. Industry or business

House Work

12. Name

Unknown

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mary B. Long Ho

(b) Address

1362 N. Calhoun St

17 (a) ☒ Burial, ☒ Cremation, or removal

Date thereof

6-4-43

(c) Cemetery or crematory

Calvary

18 (a) Funeral director

Sam H. Chase Inc

(b) Address

638 N. Calhoun St

19 (a) OCT 4 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

1362 N. Calhoun St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/30/43 1943, 10:00 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Sept 16 1943 to Sept 30 1943 and that I last saw him alive on Sept 28 1943.

Immediate cause of death

Cerebral Hemiplegy

Due to

Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Harry F. Brown

Address 1835 Madison St Date signed 10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08732
201175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

136 08732
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JONES HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

957 N Wolfe St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LEROY SOUTHERLAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

BLACK

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

MARIE

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.)

1895

8. AGE:

48

Years

Months

Days

If less than one day

hr

min.

9. Birthplace

NC

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

FATHER
MOTHER

12. Name

JOHN SOUTHERLAND

13. Birthplace

NC

14. Maiden Name

LIZA JOHNSON

15. Birthplace

N.C.

16 (a) Informant

RECORDS

(b) Address

JONES HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct 6 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Lawrence Cemetery

Location

St. Lawrence Cemetery

18 (a) Funeral director

Mr. A. P. Elliott

(b) Address

1129 N. Caroline St.

19

OCT 4 - 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1943 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Miliary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John R. Birmingham

Address

JRH

Date signed 10-3

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G 08733
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1361 N. Carey St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

65 1 10 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address 1361 N. Carey St.

17 (a) Burial, cremation, or removal

(b) Date thereof Oct. 4, 1943

(c) Cemetery or crematory

Location Baltimore, Md.

18 (a) Funeral director

(b) Address 1631 Union Ave.

19 OCT 4 - 1943

Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1361 N. Carey St.

(e) Citizen of foreign country? No (If yes, give location) (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1943 at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1943 to Sept 30 1943, and that I last saw him alive on Sept 29 1943.

Immediate cause of death

Cardio Vascular

Disease

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. William Frey

Address 1928 Pa. Ave Date signed 10/2/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08734
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **607 Dolphin St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **17**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **607 Dolphin St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EMMA THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex **Female** 5. Color or race **Colored** 6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 10, 1874**

8. AGE: Years **72** Months **4** Days **21** If less than one day
hr. min.

9. Birthplace **Calvert Co., Md.**
(Town, county, and state)

10. Usual Occupation **None**

11. Industry or business

12. Name **Jesse Whittington**

13. Birthplace **Md.**

14. Maiden Name **Martha Hardy**

15. Birthplace **Md.**

16 (a) Informant **Mrs Katie Banks**

(b) Address **607 Dolphin St.**

17 (a) **Burial** (b) Date thereof **10-5-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Calvary Cem.**
Location **A. A. Co., Md.**

18 (a) Funeral director **Mrs Frances A. Hemsley**

(b) Address **578 W. Biddle St.**

19 (a) **OCT 4 - 1943** (b)
at **for Williams, M.D.**
VS 114 Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH **October 1, 1943** at **6:30 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **9-1-1943** to **10-1-1943** and that I last saw him alive on **9-29-1943**

Immediate cause of death **Hypertension**
Cardiovascular
Atherosclerosis Duration **9 yrs**

Due to

Due to

Other Conditions **Cancer of Intest**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **W. Atwell Jones**

Address **554 Dolphin St.** Date signed **10-4-43**
M. D.

G 08735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH93d ✓ G 08735
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1106 Brewer St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1106 Brewer St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Clista Burgess Moore

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Richard Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 7, 1888

8. AGE:

Years

Months

Days

If less than one day

55224

hr. min.

9. Birthplace

A. A. Co. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

William Jones

13. Birthplace

Md.

MOTHER

14. Maiden Name

Isabelle Burgess

15. Birthplace

Md.

16 (a) Informant

William Jones

(b) Address

613 W. Pennock St.17 (a) Burial(b) Date thereof 10-5-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion Cem.

Location

Baltimore, Md.

18 (a) Funeral director

Mr. James A. Hemmley

(b) Address

518 W. Biddle St.19 (a) OCT 4 1943

Registrar

Date of registration

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1943, at 4 P.M.21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Arteriosclerosis
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature

Robert C. Graham M.D.

Date signed

October 3 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08736

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

DANIEL J Mc GARRY

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-09-6378

4. Sex

MALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

MARY P. Mc GARRY

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.)

Aug. 13, 1887

8. AGE: Years

56

Months

1

Days

18 20

If less than one day

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

PRINTER

11. Industry or business

Balto. Sun

FATHER
MOTHER

12. Name

THOMAS Mc GARRY

13. Birthplace

MD (Balto.)

14. Maiden Name

MARY P. Mc MANUS

15. Birthplace

Balto.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cem.

Location

Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

1-1943

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1409 W 37th St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH. October 3, 1943, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22, 1943, to Oct 3, 1943.

and that I last saw him alive on Oct 3, 1943.

Immediate cause of death

Coronary failure

Due to

uræmia

Due to

carcinoma of bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edw. J. Richardson, Jr.

M. D.

Address

Johns Hopkins Hosp.

Date signed 10/3/43

Duration

at least

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>Calvert St.</u> (c) Hospital or institution: <u>Mercy</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>3 6 14</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>			2. USUAL RESIDENCE OF DECEASED: (a) State <u>MD</u> (b) County _____ (c) City or town <u>Balto.</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>2038 Druid Park Drive</u> (If rural give location) (e) Citizen of foreign country? <u>No</u> (Yes or No) If yes, name country _____		
3 (a) FULL NAME <u>Carolyn S. Foxwell</u> 3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____			MEDICAL CERTIFICATION		
4. Sex <u>F</u>	5. Color or race <u>W</u>	6 (a) Single, married, widowed, or divorced. <u>Single</u>	20. DATE OF DEATH <u>10/3</u> 19 <u>43</u> at <u>1:30</u> A.M.		
6 (b) Name of husband or wife _____ 6 (c) If alive, give age _____ years			21. I certify that death occurred on the date above stated; that I attended deceased from <u>June 14</u> 19 <u>43</u> to <u>10/3</u> 19 <u>43</u> , and that I last saw her alive on <u>10/2</u> 19 <u>43</u> .		
7. Birth date of deceased (mo., day, yr.) <u>6/5/1940</u>			Immediate cause of death <u>Cerebral Hemorrhage</u>		
8. AGE: Years Months Days If less than one day <u>3</u> <u>28</u> hr. min.			Due to <u>Hypertension</u>		
9. Birthplace <u>Balto.</u> (Town, county, and state)			Due to _____		
10. Usual Occupation _____			Other Conditions _____		
11. Industry or business _____			(Include pregnancy within 3 months of death)		
12. Name <u>Carl S. Foxwell</u>			Date of operation _____		
13. Birthplace <u>Balto., Md.</u>			Major findings of operations _____		
14. Maiden Name <u>Irma Seward</u>			of autopsy _____		
15. Birthplace <u>Balto., Md.</u>			22. If death was due to external causes, fill in the following:		
16 (a) Informant <u>Mother</u>			(a) Accident, suicide, or homicide _____		
(b) Address _____			(b) Date of occurrence _____ at _____ M		
17 (a) _____ (b) Date thereof <u>10/4/43</u> (Burial, cremation, or removal) (month) (day) (year)			(c) Where did injury occur? _____ (City or town) (County) (State)		
(c) Cemetery or crematory <u>Maryland</u> Location <u>Balto., Md.</u>			(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)		
18 (a) Funeral director <u>Wm. J. [unclear]</u>			(e) Means of injury _____		
(b) <u>OCT 4 1943</u>			23. Signature <u>J. E. Sweeney</u>		
19 (a) _____ (b) _____ (Date rec'd by registrar) Registrar			Address <u>Mercy Hosp.</u> Date signed <u>10/3/43</u>		

G 08738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08738
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **2627 E. Monument St.**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **29 Years**
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **2627 E. Monument St.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Annie L. Hoffheiser,

3 (b) If veteran, name war

3 (c) Social Security Account

No. **None**

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White**Widow**6 (b) Name of husband or wife **Albert Hoffheiser,**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **October 29, 1866**

8. AGE:

Years

Months

Days

If less than one day

76**11****3**

hr.

min.

9. Birthplace

Stiltz Md.

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

FATHER
MOTHER12. Name **Henry Baker,**13. Birthplace **Maryland**14. Maiden Name **Sarah Fuhrman,**15. Birthplace **Maryland**16 (a) Informant **Mrs Catherine M. Gulber,**(b) Address **2627 E. Monument St.**17 (a) **Burial** (b) Date thereof **Oct. 6, 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **Bethlehem**Location **Cordorus Penna.**18 (a) Funeral director **Robert S. Little,**(b) Address **2700 Edmondson Ave**

19 (a) (b)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT 2 1943** 19 **at 5:45 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **9/27/43** 19 to **10/2/43** 19, and that I last saw her alive on **10/2/43** 19.

Immediate cause of death

Cerebral Hemorrhage (apoplexy)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Joseph Pokorny M.D.Address **2200 E. Madison St.** Date signed **10/3/43**

Duration

1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 4-1943

G 08739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH168 G 08739
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Baltimore, Md.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 329 Dolphin Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

ARTHUR HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-01-2470

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 2-1878

8. AGE: Years

Months

Days

If less than one day

64651129

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Banker

11. Industry or business

Central Savings Bank

12. Name

John B. Howard

13. Birthplace

Md.

14. Maiden Name

Emily Winchester

15. Birthplace

Md.

16 (a) Informant

Ellen Howard

(b) Address

329 Dolphin St

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 4/43

(month, day, year)

(c) Cemetery or crematory

London Park

Location

3801 Frederick Ave

18 (a) Funeral director

John Outtishell

(b) Address

1900 Eutaw Place

19 (a)

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1943 at 3:55 A. M.21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractures, multiple bones of face.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10-1-43 at 8:45 P. M.(b) Where did injury occur North side of Dolphin St. between Eutaw & Jordan Sts.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public placeWhile at work? No

Struck on head by blunt instru

ment, & then struck by trackles

23. Signature

H. W. Williams, M.D.

Medical Examiner.

Date signed

10-2-43

Please write the causes of death clearly and legibly.

G 08739

G 08741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G 08741

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 903 M CLean Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State W. Va (b) County Berkeley

(c) City or town Martinsburg
(If outside city or town limits, write RURAL and give town)(d) Street No. Virginia Ave
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

James Russell Stuckey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Marie Stuckey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1899

8. AGE: Years 44 Months 43 Days 1 If less than one day 26 hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation crane operator

11. Industry or business Pittsburgh Steel

12. Name J W Stuckey

13. Birthplace W. Va

14. Maiden Name Mattie J Wheeler

15. Birthplace W. Va

16 (a) Informant Jesse L Stuckey

(b) Address 1946 W. Lawrence St

17 (a) Burial (b) Date thereof 10-6-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Presby Mission Am

Location Martinsburg W. Va

18 (a) Funeral director F C Nigumbatham

(b) Address Ellicott City, Md

19 (a) (b)

(Date and place of burial)

OCT 1 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1943 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943, to Oct 4 1943, and that I last saw him alive on Oct 4 1943.

Immediate cause of death

Lobar Pneumonia

Coronary Thrombosis

Due to Acute Pulmonary Edema

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

Major findings:

Of operations.

Of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury.

23. Signature Samuel S. Wolfe

Address 1321 C. Pratt Ave

Date signed 10-4-43

M. D.

Date signed 10-4-43

Date signed 10-4-43

Date signed 10-4-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08742

117d Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

62

5

-

hr.

min.

9. Birthplace

Baltimore md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Date of death)

20. DATE OF DEATH

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 2, 1943, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1942, to Oct 2 1943, and that I last saw him alive on Oct 2 1943.

Immediate cause of death

Post-operative shock
Pneumonia

Due to

Due to

Other Conditions

Arteriosclerosis
Vascular disease & block.

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

G 08743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08743

JL - 83562

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

3 (a) FULL NAME

Sara A. Brown

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1861

8. AGE: Years

82

Months

2

Days

22

If less than one day

hr.

min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Rev. H. W. Peeples

13. Birthplace

Va.

MOTHER

14. Maiden Name

Eliza Nelson

15. Birthplace

N. C.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/5/43

(c) Cemetery or crematory

Lonsdale Park

Location

Windsor Mill Road

18 (a) Funeral director

Howard T. Blight Jr.

(b) Address

42914 Belair Road

19 (a)

OCT 4 1943

VB 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2653 Maryland Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 1943 at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-43 to 10-2-43 and that I last saw him alive on 10-2-43.

Immediate cause of death

Broncho pneumonia

Due to

Fracture neck of Rt. Femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-3-43

Major findings of operation: Fract. Neck Rt. Femur

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 8-31-43 at ? M

(c) Where did injury occur? Baltimore City (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? park - Wyman's While at work? No (Specify type of place)

(e) Means of injury Fall

23. Signature Ronald P. Helt

M. D.

Date signed 10-3-43

For S.M.L. Graham, by Howard T. Blight, Jr., M.D.

FURNISH WHITE PEARLS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH832 ✓ G 08744
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1943, at 11:20 AM

21. I certify that death occurred on the date above stated that I attended deceased from Sept 7, 1943, to Oct 1, 1943, and that I last saw him alive on Oct 1, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. D.

Address 4632 Daniel Hill Lane

10-2-43

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08745
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ida Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Female

5. Color or race
Colored

6 (a) Single, married, widowed, or divorced.
Widowed

6 (b) Name of husband or wife William (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years Months Days If less than one day
49 ? ? ? hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10/6/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium West Port Ind. George P. S. Gibson
Location

18 (a) Funeral director

(b) Address 1735 Spring Hill Ave
Huntington Williams

OCT 4 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1943 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1943 to 10-3-43 and that I last saw him alive on 10-2-43.

Immediate cause of death

Stomach
hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul M. M.

Address B. C. Date signed 10/3/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08746
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 da.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 916 Barre St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Arthur J. Benson

83021

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1884

8. AGE:

Years

Months

Days

If less than one day

58

10

9

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Jess Benson

13. Birthplace

Md.

14. Maiden Name

Emma Polton

15. Birthplace

?

16 (a) Informant

Hospital records

(b) Address

4940 Eastern Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/5/43

(c) Cemetery or crematory

Loudon Park

Location

Fredrick rd

18 (a) Funeral director

Ambrose Inc

(b) Address

414 N. Franklin St

19

(a) Date of death

Oct 1 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1943 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 3 1943 to Oct. 1 1943

and that I last saw him alive on Oct. 1 1943

Immediate cause of death

Pulmonary tuberculosis

Duration

3 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul Helt

Address

R.C.H.

Date signed

M. D.

10-2-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08747
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7015 Harford Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(d) Street No. 7015 Harford Rd

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Grace Kreiner

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

William

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

Sept 16, 1883

8. AGE:

Years

Months

Days

If less than one day

60

15

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

11. Industry or business

At Home

FATHER
MOTHER

12. Name

Michael Biser

13. Birthplace

Germany

14. Maiden Name

Brenda

15. Birthplace

Germany

16 (a) Informant

William Kreiner

(b) Address

7015 Harford Rd

17 (a)

burial

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Bethel Rd.

18 (a) Funeral director

M. W. E. Duppel

(b) Address

Howard & Ann Sts.

19 (a)

OCT 4 - 1943

Huntington Avenue, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1943 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1943 to Oct 1, 1943, and that I last saw her alive on Oct 1, 1943.

Immediate cause of death

Carcinoma of Rectum
Metastatic Carcinoma of
Liver

Duration

7 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

1331 E. Pratt Ave

M. D.

Date signed 10-2-43

PRINTED MATTER, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 08748	
CERTIFICATE OF DEATH		926 Registered No.	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>311 E. 28th St.</u> (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>12</u> (e) Length of stay in Baltimore (yrs., mos., or days)		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md.</u> (b) County (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>311 E. 28th St.</u> (If rural give location) (e) Citizen of foreign country? <u>no</u> (Yes or No) If yes, name country	
3 (a) FULL NAME <u>John Henry Hofmann</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced <u>Married</u>	
6 (b) Name of husband or wife <u>Mary J. Hofmann</u>		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>July 10 - 1888</u>			
8. AGE: Years <u>55</u>	Months <u>2</u>	Days <u>20</u>	If less than one day hr. min.
9. Birthplace <u>Baltimore Md.</u> (Town, county, and state)			
10. Usual Occupation <u>Postman</u>			
11. Industry or business <u>U.S. Mail</u>			
12. Name <u>Henry Hofmann</u>			
13. Birthplace <u>Germany</u>			
14. Maiden Name <u>Anna Boopre</u>			
15. Birthplace <u>Germany</u>			
16 (a) Informant <u>Mrs. Mary J. Hofmann</u>			
(b) Address <u>311 E. 28th St.</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>Oct 5 - 1943</u> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Holy Cross</u> Location <u>Anne Arundel Co.</u>			
18 (a) Funeral director <u>Elizabeth Hark Ins.</u>			
(b) Address <u>115 E. May St.</u>			
19 (a) <u>Oct 4 - 1943</u> (Date of registration) <u>Huntington Williams</u> (Signature)			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Sept 30</u> 19 <u>43</u> at <u>7:50 PM</u>			
21. I certify that death occurred on the date above stated; that I attended deceased from <u>June 9</u> 19 <u>43</u> to <u>Sept 30</u> 19 <u>43</u> and that I last saw him alive on <u>Sept 28</u> 19 <u>43</u>			
Immediate cause of death <u>Myocardial Insufficiency</u>		Duration	
Due to			
Due to			
Other Condition <u>Valvular Endocarditis</u>		PHYSICIAN	
<u>Myocardial Insufficiency</u> (Include pregnancy within 3 months of death)		Underline the cause to which death should be charged statistically.	
Date of operation			
Major findings of operation			
of autopsy			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence _____ at _____ M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?			
(Specify type of place)			
(e) Means of injury			
23. Signature <u>John J. Scheuch</u> Address <u>1357 S. Charles St.</u> Date signed <u>10/2/43</u>			

441910 08749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08749

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1114 S. Charles

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

CARROLL SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-26-04

8. AGE:

Years

Months

Days

If less than one day

39

8

45

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Military Police

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Smith

13. Birthplace

VA

14. Maiden Name

Elizabeth Robinson

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct. 5-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oscar Hill

Location

Anne Arundel Co.

18 (a) Funeral director

Elizabeth Harle Guss

(b) Address

115 Co. West St.

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 1

1943, 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1943, to Oct 1 1943, and that I last saw him alive on Oct 1 1943.

Immediate cause of death

? Hodgkins Disease

Duration

2 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

? Hodgkins disease

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J H H

M. D.

Date signed 10-2

VS OCT 4-1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08750

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2922 Northern Parkway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John Reicher + (REICHERT)

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-01-1158

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Josephine Reicher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 17, 1883

8. AGE: Years Months Days

60 2 13

If less than one day

hr. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

Hutzler Bros.

MOTHER FATHER

12. Name

John Reicher

13. Birthplace

Germany

14. Maiden Name

Rosina Hahn

15. Birthplace

Germany

16 (a) Informant

Mrs. Josephine Reicher

(b) Address

2922 Northern Parkway

17 (a) Burial

(b) Date thereof Oct. 4, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore

18 (a) Funeral director

Philip's Moving Sons

(b) Address

2024 Orleans St.

19 (a)

OCT 4 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

9/30 1943 at 8:20 P M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to natural death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. McHally, M.D.

Date signed

10/1/43

08751

IL - 83168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08751

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
1 - 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and town)
(d) Street No. 812 Register Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Elizabeth Lambden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1879

8. AGE: Years Months Days If less than one day
64 3 19 9 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Patrick Carroll

13. Birthplace England

14. Maiden Name Catherine ?

15. Birthplace England

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct 5, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin J. J. & Sons

(b) Address 1827 N. North Ave.

19 OCT 4, 1943 (b) H. H. Williams, M.D.

VB 140

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1943 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1943 to 10-1 1943, and that I last saw him alive on 10-1 1943.

Immediate cause of death

Bronchopneumonia

Due to Fracture of Hip

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accidental fall

(b) Date of occurrence May 17, 1943 at ? M

(c) Where did injury occur? 2002 Eastern Ave. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home ? none While at work? no (Specify type of place)

(e) Means of injury Tripped and fell from stairs

23. Signature H. H. Williams, M.D.

Address Baltimore City Date signed 10-2-43

For P. H. Graham, or Howard J. Mahoney, M.D.

NEVER WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08752

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08752
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Caton & Wilken Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County Baltimore
(c) City or town Colonsville Md
(d) Street No. Seunville Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Bernard Frankel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male 5 Color or race White 6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Eleanor
Bernard Frankel 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1874

8. AGE: Years 69 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Baltimore Md.

10. Usual Occupation Superior Mfg.

11. Industry or business

12. Name George Frankel

13. Birthplace Germany

14. Maiden Name Mary Ann

15. Birthplace Wales

16 (a) Informant Mr. Bernard Frankel

Seunville Ave Colonsville

17 (a) Burial (b) Date thereof Sept 5, 1943

(c) Cemetery or place of interment St Agnes Cemetery

Location Baltimore

18 (a) Funeral director Easton Sons

(b) Address 444 E. Caton

OCT 4 - 1943

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/43 19 43 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28/43 19 43 to 10/1/43 19 43, and that I last saw him alive on 10/1/43 19 43.

Immediate cause of death Terminal Pneumonia

Due to Partial Asthmatic reaction

Due to Asthmatic carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. J. Bryan M.D.

Address St Agnes Hosp Date signed 10/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08753
T.N

83876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08753
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave**
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) **13 Days**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **418 N. Wolfe St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Helen Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **Colored** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **AUG, 27, 1912**

8. AGE: Years **31** Months **1** Days **4** If less than one day hr. min.

9. Birthplace **Va.**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name **John Barley**
13. Birthplace **Va.**

MOTHER 14. Maiden Name **Rosie Hughes**
15. Birthplace **Va.**

16 (a) Informant **Baltimore City Hospitals**
(b) Address **4940 Eastern Ave (Records)**

17 (a) **Burial** (b) Date thereof **10/6/43**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location **Danville, Va.**

18 (a) Funeral director **Elroy Wilson**
(b) Address **1000 Cranberry Ave**

19 (a) **OCT 4 - 1943**
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **10-1-43** 19 **at 9:55 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **9-18 1943 to 10-1 1943**, and that I last saw her alive on **10-1 1943**.

Immediate cause of death
Cerebral embolism

Duration
7 hrs

Due to **Subacute Bacterial Endocarditis**

Due to **Rheumatic heart disease**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **As above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Paul R. [illegible]**

Address **Ber** Date signed **10/2/43**

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08754

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 510 Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 510 Park Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MARY E MONAHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1896

8. AGE: Years 47 Months 5 Days - If less than one day hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

seam work

11. Industry or business

FATHER
MOTHER

12. Name

?

13. Birthplace

14. Maiden Name

?

15. Birthplace

16 (a) Informant Nellie Holloman

(b) Address 109 Brentwood Ave

17 (a) Burial (b) Date thereof Oct 5, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Peter's

Location Baltimore

18 (a) Funeral director Rita Woodfield

(b) Address 914 Greenmount Ave

19 (a) OCT 4 - 1943 Registrar William M. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1943, at 6 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature A. J. Wollman M.D.

Date signed 10-2-43

G 08755

PALMER

BALTIMORE CITY HEALTH DEPARTMENT

G 08755

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr)

8. AGE:

Years

Months

Days

If less than one day

77

78

11

14

hr.

min.

9. Birthplace

Eastern Shore Md

10. Usual Occupation

Homestic

11. Industry or business

12. Name

Netter Collins

13. Birthplace

Eastern Shore Md

14. Maiden Name

Henrietta Surpin

15. Birthplace

Eastern Shore Md

16 (a) Informant

James Collins

(b) Address

2207 Christian St

17 (a)

Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

West Port

18 (a) Funeral director

J Brooks

(b) Address

1463 N. Carey St

19 (a)

(b)

OCT 4 1943

VB 100

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

All yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 2

19

at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from

June 4 1943

and that I last saw him

alive on

Oct 2 1943

Immediate cause of death

Cerebral thrombosis

Hypertension

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

067-4-1943

08757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08757

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1042 Rodman Way

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

James Robert Owen (James Robert Owen)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10-2-32

8. AGE:

Years

Months

Days

If less than one day

11

hr.

min.

9. Birthplace Md (Baltimore)

(Town, county, and state)

10. Usual Occupation

student

11. Industry or business

FATHER
MOTHER12. Name Joseph C. Owen13. Birthplace Balto., Md14. Maiden Name Alma Mack15. Birthplace Md16 (a) Informant Records

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/5/43

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location

Balto., Md.18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address

Balto., Md.19 OCT 4 - 1943

(Date rec'd by)

William J. Tickner, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 2 1943, at 1:25 PM21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1943 to Oct 2 1943 and that I last saw him live on Oct 2 1943

Immediate cause of death

Brain tumor? Brain

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Chas RandolAddress Johns Hopkins Hosp.Date signed 10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

133 b G 08758
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 334 Calvert
(c) Hospital or institution: Union Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lathrop Apartment
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MR. Hallie V. ROBERTS (Hollis) (Hallis) Holiday V. Roberts

3 (b) If veteran, name war

?

3 (c) Social Security Account

No. 213-01-2268

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

--

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE:

Years 58 Months 11 Days 21 hr. min.

9. Birthplace

Maryland (Lakesville)

10. Usual Occupation

Wholesale Plumbing

11. Industry or business

Self-employed

12. Name

Mr. George Roberts

13. Birthplace

Maryland (Lakesville)

14. Maiden Name

Mary Ellen Andrews

15. Birthplace

Maryland

16 (a) Informant

Mr. John T. Roberts

(b) Address

5 Wendover Rd. City

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/5/43

(c) Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md. William M. R.

19 (a) OCT 4 - 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 3 1943 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1943 to Oct. 3 1943, and that I last saw him alive on Oct. 3 1943.

Immediate cause of death

Cardio. Resp. failure

Due to

Necrosis from Rt. Kidney

Due to

Pericarditis etc.

Other conditions

Stone Rt. Kidney & Pyelitis

(Include pregnancy within 3 months of death)

Date of operation

Sept. 29

Major findings of operation

Pericarditis etc.

of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury
23. Signature Willard L. Williams
Address Union Memorial Hosp Date signed 10/3/43

Duration

3 days

12-15 days

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08759

BALTIMORE CITY HEALTH DEPARTMENT

G 08759

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address: 5313 Edmondson Ave.
- (c) Hospital or institution:
Hood Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 28
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
- (d) Street No. (If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDITH JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced single

- 6 (b) Name of husband or wife. --
- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1899

8. AGE: Years 43 Months 10 Days 26 If less than one day
hr. min.

9. Birthplace Liverpool, England
(Town, county, and state)

10. Usual Occupation

11. Industry or business Glenn L. Martin

12. Name Thomas Joseph Jones

13. Birthplace Liverpool, Eng.

14. Maiden Name Mary E. Boyes

15. Birthplace Liverpool, Eng.

- 16 (a) Informant Harold Roberts

- (b) Address 1910 Englewood Ave.

- 17 (a) Burial (b) Date thereof 10/5/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Woodlawn Cem.

- Location Woodlawn, Md.

- 18 (a) Funeral director WM. J. TICKNER & SONS

- (b) Address Balto., Md.

- 19 (a) OCT 4 - 1943 William M.P.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/ 19 43 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Acute Coronary Failure

- Due to Brain Tumor
(Malignant)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

- Date of operation Sept 1942

- Major findings of operation: Brain Tumor

- of autopsy: none

22. If death was due to external causes, fill in the following

- (a) Accident, suicide, or homicide

- (b) Date of occurrence at M

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

- (e) Means of injury

23. Signature William M.P.

- Address Catonsville

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08760
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.

(e) Length of stay in Baltimore (yrs., mos., or days) same

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

9/25/43

If less than one day

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Bertram Delavie

13. Birthplace Baltimore Md.

14. Maiden Name Grace Grannis

15. Birthplace

Calif.

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10-6-43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Rusk

(b) Address

5305 Mayford Rd.

19 (a)

(b) Registrar

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

6 Brainwood Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/43 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25/43 1943, to 10/3/43 1943, and that I last saw him alive on 10/3/43 1943

Immediate cause of death

abscess of duodenum and rectum

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ronald B. Rusk

Address

Mary Knapp

Date signed 10/3/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08761

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08761

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4008 Chesmont Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4008 Chesmont Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas B. Howard

3 (b) If veteran, name war

3 (c) Social Security Account
No. -

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Rose Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-1873

8. AGE: Years 70 Months 1 Days 21 If less than one day
hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Hiram Howard

13. Birthplace Ba

14. Maiden Name Mary Guy

15. Birthplace Va

16 (a) Informant Mrs Rose Howard

(b) Address 4008 Chesmont Ave

17 (a) Burial (b) Date thereof 10-5-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Leonard J. Ruck

(b) Address 2051 Harford Rd

19 (a) (b)

(Date rec'd by registrar)

VS 155

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1943 at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29, 1943 to Oct 1, 1943, and that I last saw him alive on Sept 30, 1943.

Immediate cause of death
Myocarditis

Duration
not definite

Due to

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Ray S Hayden

23. Signature Ray S Hayden

Address 3114 Harford Rd Date signed 10-9-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08762

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd. & Calvert St.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2207 Kirk Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

George Thomas Savage

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1884

8. AGE: Years 59 Months 11 Days 11 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Stock clerk

11. Industry or business Hochstadt, Kohn Co.

12. Name John Savage

13. Birthplace Ireland

14. Maiden Name Elizabeth Duffey

15. Birthplace Ireland

16 (a) Informant Mrs Wm H. Hargan.

(b) Address 649 Bartlett Ave.

17 (a) Burial (b) Date thereof 10-5-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M. Wiedefeld

(b) Address 501 E. 12th St.

19 OCT 4 1943 (b) Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1943, at 2:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1943, to Oct. 2 1943, and that I last saw him alive on Oct. 2 1943.

Immediate cause of death Cancer - respiratory failure

Duration

7 mos.

Due to Cachexia

Due to Carcinoma of nasopharynx

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. W. Mungert Jr.
Address 322 E. University Pkwy. Date signed 10/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08763

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2123 Maisel Street

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 204

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2123 Maisel St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ottilia

Raake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Charles Raake

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

Feb 26-1888

8. AGE:

Years

Months

Days

If less than one day

55

67

67

hr.

min.

9. Birthplace

Vienna

Austria

(Town, county, and state)

10. Usual Occupation

at Home

11. Industry or business

FATHER

12. Name

Mathias Obermiller

13. Birthplace

Stadl-Paura Austria

MOTHER

14. Maiden Name

Maria Stiner

15. Birthplace

Meran - Austria

16 (a) Informant

Charles Raake

(b) Address

2123 Maisel Street

17 (a)

Burial

(b) Date thereof

Oct 6-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore Md.

18 (a) Funeral director

John C. Miller Inc.

(b) Address

2435 E. Oliver Street

19 (a)

OCT 4 - 1943

Registrar

MEDICAL CERTIFICATION

80

20. DATE OF DEATH October 3rd 1943 at 12 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic myocardial

degeneration

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, in farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed

October 3rd 1943

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08764

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **3127 WEAVER AVE.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

LI FE

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County

(c) City or town **BALTIMORE**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **3127 WEAVER AVE.**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

EDGAR R. EY

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. **212 03 1369**

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

LUCY EY

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.) **OCT. 28-1 897**

8. AGE: Years

45

Months

11

Days

25

If less than one day

hr.

min.

9. Birthplace **BALTIMORE MD.**

(Town, county, and state)

10. Usual Occupation

SHIPPING CLERK

11. Industry or business

CONTINENTAL ROOF CO.

FATHER

12. Name **HENRY EY**

MOTHER

13. Birthplace **BALTIMORE MD**

14. Maiden Name **JOSEPHINE TSANDERS**

15. Birthplace **BALTIMORE MD.**

16 (a) Informant **ELNORE THANNER (SIS TER)**

(b) Address **2765 CHESTERFIELD AVE .**

17 (a) **BURIAL**

(Burial, cremation, or removal)

(b) Date thereof **OCT. 6/48**

(month) (day) (year)

(c) Cemetery or crematory **PARKWOOD CEM.**

Location **TAYLOR AVE.**

18 (a) Funeral director **Lilly and Geiler INC.**

(b) Address **403 E. WOLFE ST.**

OCT 4 1948

(b) **Huntington Williams**

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT. 3** 19 **43** at **2/15 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Dec. 15 1941** to **10/3 1943**, and that I last saw him alive on **10/3 1943**.

Immediate cause of death

Cornary artery thrombosis

Duration

48 HRS.

Due to **Cornary arteriosclerosis**

2 yrs +

Due to

Other Conditions **Arterial Hypertension**

2 yrs +

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John W. Williams

Address

6304 Belair Rd

Date signed **10/3/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

The

442182
G 08765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08765

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DA 8.

(e) Length of stay in Baltimore (yrs., mos., or days) 6 MOS.

3 (a) FULL NAME

Joyce L HART

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or

divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-31

8. AGE: Years Months Days If less than one day

12

5

29

hr.

min.

9. Birthplace

Ohio

(Town, county, and state)

10. Usual Occupation SCHOOL GIRL

11. Industry or business

FATHER
MOTHER

12. Name Clifford C HART

13. Birthplace Ohio

14. Maiden Name LAURA THACKLER

15. Birthplace Ky

16 (a) Informant

(b) Address

Records

JOHNS HOPKINS HOSPITAL

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 6/43

(month) (day) (year)

(c) Cemetery or crematory ASHLAND CEM.

Location ASHLAND KENTUCKY

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) OCT 4 - 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1223 TENNENT WAY

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1943 at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Oct 4 1943, and that I last saw her alive on Oct 4 1943.

Immediate cause of death

Brain Tumor

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 1, 1943

Major findings of operation:

Brain Tumor

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature Hugo V. Ryzgalski

Address Johns Hopkins Hosp

Date signed 10-8-43

08766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. 08766

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address PLAZA APTS. PARK AVE. & WILSON ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1/2 no

(e) Length of stay in Baltimore (yrs., mos., or days) 14 1/2 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County BALTIMORE

(c) City or town BALTO. Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. PLAZA APTS. PARK AVE. & WILSON ST.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3 (a) FULL NAME

JULIA E. LUCAS

3 (b) If veteran, name war

3 (c) Social Security Account

no

No. no

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

female

white

single

6 (b) Name of husband or wife. no

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) AUG. 9. 1879

8. AGE: Years Months Days If less than one day

64

1

23

hr.

min.

9. Birthplace W. VA.

(Town, county, and state)

10. Usual Occupation

home duties

11. Industry or business

12. Name GEORGE WM. READ

13. Birthplace W. VA.

14. Maiden Name MARY READ

15. Birthplace VA.

16 (a) Informant CORINNE P. LUCAS

(b) Address PLAZA APTS.

17 (a) burial (b) Date thereof Oct 5. 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory EDGEHILL CEMETERY

Location CHARLESTOWN W. VA.

18 (a) Funeral director J. S. Mitchell & Sons

(b) Address 1200 EUTAW PLACE

OCT 5-1943

(Date rec'd by registrar) J. S. Mitchell & Sons

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2. 1943 19 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 19 to Oct 2. 1943. and that I last saw her alive on Oct. 2. 1943.

Immediate cause of death

Coronary thrombosis
Due to Arterio-sclerosis
Myocarditis
Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address 1405 PARK AVE.

Date signed 10/14/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08767

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1119 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Linda C. Webber Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

Colored

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mo. 26 - 43

8. AGE: Years Months Days If less than one day
6 7 hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

none

12. Name George Jackson

13. Birthplace Balto

14. Maiden Name Edith Webber

15. Birthplace Balto

16 (a) Informant George Jackson

(b) Address 1119 N. Calhoun St

(a) (b) Date thereof Oct 6 - 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James A. Hayes

(b) Address 142 W. Hill St.

19 (a) OCT 5 - 1943 Huntington Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1943, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1943 to 10-3-1943 and that I last saw her alive on 10-2-1943

Immediate cause of death

Acute Enteritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. F. Howell M. D.

Address 609 N. Carroll St Date signed 10/4/43

G 08768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08768

Registered No.

131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 329 S. Castle St.,
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 329 S. Castle St.,
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

WILLIAM S. DAILEY

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louisa E. Dailey
 6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1865

8. AGE: Years 77 Months 11 Days 279 hr. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual Occupation Laborer —retired

11. Industry or business

12. Name Andrew Dailey

13. Birthplace Maryland

14. Maiden Name Elizabeth?

15. Birthplace Maryland

16 (a) Informant Mrs. Louisa E. Dailey

(b) Address 329 S. Castle St.,

17 (a) Burial (b) Date thereof Oct. 5, 1943
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Trinity
 Location Baltimore, Md.

18 (a) Funeral director Ulerich Funeral Home

(b) Address 2008 Orleans St.,

19 (a) OCT 5 - 1943 Huntington Williams

VS 140

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1943 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Oct 3 1943, and that I last saw him alive on Oct 2 1943.

Immediate cause of death

Thrombosis pulmonary artery
 Cardio-vascular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Louis N. Krumm M. D.

Address 722 N. Leonard St. Date signed Oct 4/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08769

MJ-79956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 e

G 08769
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos., 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 765 W. Lexington St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Robert Waller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1882

8. AGE: Years Months Days If less than one day

61

3

29

hr.

min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Walter

13. Birthplace

Virginia

14. Maiden Name

Page Clay

15. Birthplace

Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL OCT 4 1943

18 (a) Funeral director

Commissioner of Health

19 (a) OCT 5 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1943, at 7:20 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943, to 9/26 1943, and that I last saw him alive on 9/26 1943.

Immediate cause of death

Bronchopneumonia

Duration

?

Due to

Due to

Other Conditions Lethal C.V.

cholesterol

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Sermon

Address

13 CH

Date signed 9/30

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08770
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Baltimore City Hospitals**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **13 yrs. 10 mos.**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County **Baltimore**
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **432 N. Register St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Alfred Dennis

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **10-18-95**

8. AGE: Years Months Days If less than one day

47**11****9****hr.****min.**9. Birthplace **Baltimore, Maryland**

(Town, county, and state)

10. Usual Occupation **Laborer**

11. Industry or business

12. Name **Alfred Dennis**13. Birthplace **Maryland**14. Maiden Name **Ida Riley**15. Birthplace **Maryland**16 (a) Informant **Records**(b) Address **Baltimore City Hospitals**17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **UNIVERSITY MEDICAL SCHOOL**
Location **Commissioner of Health** **OCT 4 1943**

18 (a) Funeral director

(b) Address **Huntington Williams, M.D.**
19 (a) **OCT 5 1943** (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 27 1943 at 1:40 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **11-27-1939 to 9-27-1943**, and that I last saw him alive on **9-27-1943**.

Immediate cause of death

Hypertensive cardio-vascular disease

Duration

Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Chas. L. Schmitt**Address **Baltimore City Hospitals** Date signed **9-27-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

440417
G 08771

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

550
G 08771
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **MD** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1621 Jefferson St.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-11-76

8. AGE:

Years

Months

Days

If less than one day

67

1

20

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Balton Smith

13. Birthplace

Va.

14. Maiden Name

Marje ?

15. Birthplace

Va.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

W. Calver

Location

18 (a) Funeral director

Elroy Wilson

(b) Address

1000 Branch St. N. W.

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 1 1943 at 8:25

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 30 1943** to **Oct 1 1943** and that I last saw him live on **Oct 1 1943**

Immediate cause of death

Respiratory failure

Due to

Diffuse CARCINOMATOSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: **diffuse carcinomatosis**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John H. Kohre

Address **Johns Hopkins Hosp.**

Date signed

10-1-43

G 08772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 Registered No. 08772

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1642 Congress St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 202 N. Bradford St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

LEANDER PRES BURY

3 (b) If veteran, name war

WORLD WAR #7

3 (c) Social Security Account

No. 220-01-4645

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2, 1943 7AM

4. Sex

m

5. Color or race

Cauc

6 (a) Single, married, widowed, or divorced.

Separated

6 (b) Name of husband or wife HELEN VICTORIA PRES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 15, 1900

8. AGE: Years Months Days If less than one day

43

7

17

hr.

min.

9. Birthplace

Balto, Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant HELEN VICTORIA PRESBURY

(b) Address 218 N. BRADFORD ST.

17 (a) Burial (b) Date thereof 10/6/43

(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location

18 (a) Funeral director Elroy Wilson

(b) Address 1000 Barclay Ave

19 (a) Date of death 10-2-43 (b) Cause of death

(Date and by registrar) Huntington Millers, Md.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions 42

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. J. Wallenburger M.D.

Medical Examiner

Date signed 10-2-43

G 08773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08773

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 407 E. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 E. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

AUGUSTUS C. ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 18638. AGE: Years Months Days 15 If less than one day
80 8 11 hr. min.9. Birthplace New York City, N.Y.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Augustus C. Roberts13. Birthplace New York City, N.Y.14. Maiden Name Margaret Kerrigan15. Birthplace Philadelphia, Pa.16 (a) Informant Mrs. G. H. Warren
(b) Address 407 E. Lafayette Avenue17 (a) Burial (b) Date thereof 10-5-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Peace
Location Philadelphia, Pa.18 (a) Funeral director Chas. Evans & Son, Inc.(b) Address 11 & W. Mt Royal Ave.19 (a) (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1943, at 7:45 PM21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to His death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham, M.D. M.D.
Robert Lee Graham, M.D.Date signed October 5, 1943

08774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08774
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

764 W. Saratoga St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 12 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

764 W. SARATOGA ST.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 2, 1943

8. AGE:

Years

Months

Days

If less than one day

12 hr.

min.

9. Birthplace

Baltimore, Balt., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Harace ?

13. Birthplace

MOTHER

14. Maiden Name

Clidy Mae Bumper

15. Birthplace

Raleigh, N.C.

16 (a) Informant

Clidy Mae Bumper

(b) Address

764 W. Saratoga St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL OCT 5 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

OCT 5 1943

(Date rec'd by registrar)

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 3, 1943, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1943, to Oct. 3, 1943, and that I last saw her alive on Oct. 2, 1943.

Immediate cause of death

Prematurity

Duration

mat.

CONGENITAL ATROPHY

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work

(e) Means of injury

23. Signature

Address

M. A. Hoop

Date signed

10/3/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08775

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

Baltimore

(d) Street No. 403 N. Gilman St.

(e) Citizen of foreign country? (If rural give location) (Yes or No)

If yes, name country

3 (a) FULL NAME

John Washington

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or

divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1943

8. AGE: Years Months Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Pauline Washington

(b) Address 304 Gilman Street

17 (a) Wednesday (b) Date thereof Dec 6, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location

18 (a) Funeral director A. Hallett

(b) Address 918 Druid Hill ave.

19 (a) OCT 5 - 1943

Signature

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1943, at 4 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 28 1943 to Oct 3 1943.

and that I last saw him alive on Oct 3 1943.

Immediate cause of death

Non-specific Diarrhea

Duration

2 weeks

Due to

Due to

Other Conditions Maturation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08776
119a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby John W. Batt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife: Anna & Merlin Batt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/43

8. AGE: Years Months Days If less than one day

27

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name Merlin T. Batt

13. Birthplace Davis, W. Va.

14. Maiden Name Anne

15. Birthplace Allinppa, Pa.

16 (a) Informant Parents

(b) Address 2425 E. Monument Street

17 (a) Burial (b) Date Oct 5, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or place of interment: Baltimore Cemetery
Location North Ave & Res. St.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) (b)

(Date rec'd by registrar)

Registrar

OCT 5 - 1943 Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Balto.

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2425 E. Monument Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1943, at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 21, 1943, to Oct. 3, 1943, and that I last saw him alive on Oct. 3, 1943.

Immediate cause of death Epidemic
Dysentery of the
Newborn

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Ulcerations of intestinal mucosa

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Arthur Rossberg

Address St. Agnes Hosp. Date signed 10/3/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08777

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Hulkens & Caton Aves.*

(c) Hospital or institution:

St. Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2403 Eagle St.*(e) Name of foreign country *3806 Parkside Drive*

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Anne Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Husband - Vernon*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - *7-24-03*

8. AGE:

Years

40

Months

2

Days

10

If less than one day

hr. min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Dominic*13. Birthplace *Md.*14. Maiden Name *Anne Schuster*15. Birthplace *Md.*16 (a) Informant *Vernon Roberts*(b) Address *3806 Parkside Drive*17 (a) *Burial* (b) Date thereof *Oct 7, 1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Calvary Cem.*Location *Chila Rd. & Norman Ave.*18 (a) Funeral director *C. E. SCHIMUNEK*(b) Address *2601 E. Madison St.*19 (a) *OCT 5 - 1943*

(Date filed by registrar)

Huntington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 4, 1943, at M*21. I certify that death occurred on the date above stated; that I attended deceased from *9/22/43* to *10/4/43* and that I last saw her alive on *10/4/43*Immediate cause of death *Generalized Peritonitis*

Duration

Due to *Ulcerative Colitis & multiple perforations intestines*

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation *10/3/43*Major findings of operations *Same as above*

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *St. Agnes' Hosp.*Date signed *10/4/43*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				08778		082789698	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>619 Collett St</u> (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>				2. USUAL RESIDENCE OF DECEASED: (a) State <u>md</u> (b) County (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>619 Collett St</u> (If rural give location) (e) Citizen of foreign country? <u>No</u> (Yes or No) If yes, name country			
3 (a) FULL NAME <u>Mrs Netta Floyd</u> <u>216-10-0608</u>							
3 (b) If veteran, name war <u>216-10-0608</u>				3 (c) Social Security Account <u>216-10-0608</u>			
4. Sex <u>Female</u>		5. Color or race <u>Colored</u>		6 (a) Single, married, widowed, or divorced <u>Widowed</u>			
6 (b) Name of husband or wife <u>Daniel Floyd</u>				6 (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>Feb 1882</u>							
8. AGE: Years <u>61</u>		Months <u>8</u>		Days _____		If less than one day hr. _____ min. _____	
9. Birthplace <u>Baltimore md</u> (Town, county, and state)							
10. Usual Occupation <u>domestic</u>							
11. Industry or business <u>own home</u>							
12. Name <u>Wm. Gross</u>							
13. Birthplace <u>md</u>							
14. Maiden Name <u>Elizabeth Blake</u>							
15. Birthplace <u>md</u>							
16 (a) Informant <u>Jennett Furmace</u>							
(b) Address <u>1407 N. Calhoun St</u>							
17 (a) Burial <u>Int. Calhoun</u>				(b) Date thereof <u>10/7/43</u> (Month) (day) (year)			
(c) Cemetery or crematory <u>Int. Calhoun</u>							
Location <u>Int. Calhoun</u>							
18 (a) Funeral director <u>Geo. S. Nelson</u>							
(b) Address <u>13030 Reservoir</u>							
19 (a) Registrar <u>Huntington Williams, M.D.</u>							
(b) Registrar <u>Huntington Williams, M.D.</u>							
20. DATE OF DEATH <u>10-4-1943</u> at <u>1:45 AM</u>							
21. I certify that death occurred on the date above stated; that I attended deceased from <u>9-18-1943</u> to <u>10-4-1943</u> and that I last saw her alive on <u>10-3-1943</u>							
Immediate cause of death <u>Cerebral hemorrhage</u>				Duration <u>4 days</u>			
Due to <u>Hypertension + arteriosclerosis</u>				Duration <u>1-2 months</u>			
Due to _____							
Other Conditions _____							
(Include pregnancy within 3 months of death)							
Date of operation _____							
Major findings of operations _____							
of autopsy _____							
22. If death was due to external causes, fill in the following:							
(a) Accident, suicide, or homicide _____							
(b) Date of occurrence _____ at _____ M							
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____							
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____							
(Specify type of place) _____							
(e) Means of injury _____							
23. Signature <u>Frank A. Saunders</u>							
Address <u>1029 N. Sturges St</u> Date signed <u>10-5-43</u>							

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46th

G 08779

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles Filbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Alma E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1894

8. AGE:

Years

Months

Days

If less than one day

48

10

10

hr.

min.

9. Birthplace

Pa.

(Hazelton)

(Town, county, and state)

10. Usual Occupation

Accounting

11. Industry or business

FATHER

12. Name

Wm. Filbert

13. Birthplace

Pa.

(Hazelton)

14. Maiden Name

Gertrude Cury (Alroy)

15. Birthplace

Pa.

(Hazelton)

16 (a) Informant

Charles Filbert

(b) Address

4604 Mary Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/7/43

(month) (day) (year)

(c) Cemetery or crematory

Oaklawn Cem.

Location

Balto., Md.

18 (a) Funeral director

M. J. TICKNER & SONS

(b) Address

Balto., Md.

19

OCT 5 1943

(b) *Fluoridation Williams, M.D.*
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

ind

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4604 Mary Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

(Charles A. Filbert)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 4 1943, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1943, to Oct. 4 1943, and that I last saw him alive on Oct. 4 1943.

Immediate cause of death

Respiratory failure

Due to

Peritoneal sarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

9/1/43

Major findings of operations

Fibrosis of lymph nodes

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Renshaw

Address Univ. Hospital

M. D. Date signed 10/4/43

08780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08780

Registered No. 830

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 5110 Gwynn Oak Ave.
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Balto.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 5110 Gwynn Oak Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME

WILLIAM C. ABHAU

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or divorced.
married

6 (b) Name of husband or wife Gertrude Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1866

8. AGE: Years Months Days If less than one day
77 7 10 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business

12. Name Carl H. Abhau

13. Birthplace unknown

14. Maiden Name Eva Gagner

15. Birthplace Balto.

16 (a) Informant Mrs. Gertrude Lewis Abhau

(b) Address 5110 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof 10/5/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1943, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1920, to Oct. 2, 1943, and that I last saw him alive on Oct. 1, 1943.

Immediate cause of death

Arteriosclerosis with hypertension

Duration 16 yrs.

Due to Cerebral hemorrhage

with paralysis

Due to Hypostatic pneumonia

1933

Sept. 30 1943

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 10 E. Biddle St. Date signed 10-4-43

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08781
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution: **U. S. Marine Hospital**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **17 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **17 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **Washington**
(c) City or town **Hagerstown**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **220 N. Jonathan Street**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME **JOHN ROBERT KEYSER**

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
Col.

6 (a) Single, married, widowed, or divorced. **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 28, 1890**

8. AGE: Years **53** Months **4** Days **6** If less than one day
hr. min.

9. Birthplace **Hagerstown, Md.**

(Town, county, and state)

10. Usual Occupation **Cafe tender-2 1/2 yrs. ago**

11. Industry or business

FATHER 12. Name **Truman Keyser**
13. Birthplace **Hagerstown, Md.**

MOTHER 14. Maiden Name **Ruie Stripland**
15. Birthplace **? Va**

16 (a) Informant **Records, U.S. Marine Hospital**
(b) Address **Baltimore, Md.**

17 (a) **Interment** (b) Date thereof **10-5-40**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory **Hagerstown Md**
Location

18 (a) Funeral director **Isaiah L. Brown Sr**
(b) Address **D.P.W. Montgomery St**

19 (a) (Date rec'd by registrar) (b) **Huntington Williams** Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **October 4, 1943** at **6:30 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 17, 1943** to **Oct. 4, 1943**, and that I last saw him alive on **Oct. 4, 1943**.

Immediate cause of death **Hypertensive
cardio vascular disease with
auricular fibrillation.**

Duration

Undt.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation **No operation performed.**
Major findings of operation.

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy: **No Autopsy**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **None**
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature **J. Archer**
Address **Baltimore, Md.** Date signed **10/4/43**

G 08782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08782

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Isaac Keiths

3 (b) If veteran, name war

3 (c) Social Security Account

No. 2

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1910

8. AGE: Years Months Days If less than one day

33

5

H 12

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

Metal Worker

11. Industry or business

Brass Foundry

FATHER

12. Name Owen Keiths

13. Birthplace N. C.

MOTHER

14. Maiden Name Annie Mett

15. Birthplace N. C.

16 (a) Informant

John Keiths

(b) Address

156 N. Cross St

17 (a) Removal (b) Date thereof 10-5-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Wallau

Location

N. C.

18 (a) Funeral director

Isaiah L. Brown & Son

(b) Address

108 N. Montgomery St

19 (a)

OCT 5 1943 Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 156 N. Cross Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4-1943 at 12:30

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Respiratory Failure

Due to

Toxemia

Other Conditions 1st, 2nd, 3rd degree burns

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-28-43 at

21/2 P. M.

(b) Where did injury occur? River Koffer, Branch, Scott St.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Suffering a tank (chemical)

23. Signature Howard J. Wolcove

M.D.

Date signed 10-4-43

Medical Examiner.

08783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08783

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *0-0-A*(e) Length of stay in Baltimore (yrs., mos., or days) *39 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1306 Milcox Street*
(If rural give location)(e) Citizen of foreign country? *Yes* (Yes or No)
If yes, name country *Italy*

3 (a) FULL NAME

Michael Caprarola

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *214-03-3610*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of ~~husband~~ or wife *Rosaria Caprarola*6 (c) If alive, give age *56* years7. Birth date of deceased (mo., day, yr.) *April 6 1880*

8. AGE: Years Months Days If less than one day

*63**5**26**27*

hr.

min.

9. Birthplace *Civitella del Tronto Italy*

(Town, county, and state)

10. Usual Occupation *Tailor*11. Industry or business *Tailor Shop*

FATHER

12. Name *Giuseppe Caprarola*13. Birthplace *Italy*

MOTHER

14. Maiden Name *Filomena*15. Birthplace *Italy*16 (a) Informant *Angelina Verderamo (Sister in Law)*(b) Address *832 E. Preston St.*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Oct 7 1943*

(month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer Cem.*Location *Belair Rd.*18 (a) Funeral director *Frank Della Nace*(b) Address *52 N. Morley St.*

19 (a)

*OCT 5 - 1943**Antington**William M. R*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-3-1943, at 9:25 P.M.*

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractures Cervical vertebrae (broken neck)

Due to

Other Conditions *Ruptured Lungs -**Fractures leg bones - left*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *10-3-43* at *8:40 P.M.*(b) Where did injury occur *In front of 826 E. Preston St.*(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *No*(d) Means of injury *Automobile struck by automobile*23. Signature *Howard J. Wallace* M.D.Date signed *10-4-43* Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08784
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Belwood Greene St*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *3*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *4917 Catalpha Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Veltan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

Christian Veltan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 1883

8. AGE:

Years

Months

Days

If less than one day

63

5

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Adams Demmer

13. Birthplace

Germany

MOTHER

14. Maiden Name

Marianne ?

15. Birthplace

Germany

16 (a) Informant

Ernest Veltan

(b) Address

4917 Catalpha Ave.

17 (a)

Burial

(b) Date thereof

Oct 7-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Cross A.C.C.

Location

18 (a) Funeral director

Leonard G. Ruck

(b) Address

5305 Harbor Road

OCT 5 - 1943

Thurston Williams, M.D.

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-4-43 at *12:00* M

21. I certify that death occurred on the date above stated; that I attended deceased from *10-2-43* to *10-4-43*, and that I last saw him alive on *10-4-43*.

Immediate cause of death

Cerebral Vascular Accident

Due to

Arteriosclerotic C.V. Disease

Due to

Other Conditions

Carcinomatous

G.I. tract, peritoneum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Ralph J. Chasanth

Address

University Hospital

Date signed *10/7/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08785

KAMPES
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered 08785

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **1644 Carroll St**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) **9/7**
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

- (a) State **md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1644 Carroll St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Christian Kampes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife **Katherine M.**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **8-19-1871**

8. AGE: Years Months Days If less than one day

72**1****13****hr.****min.**

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

George Kampes

13. Birthplace

Germany

MOTHER 14. Maiden Name

Anna Auel

15. Birthplace

Germany

16 (a) Informant

Katherine Kampes

(b) Address

1644 Carroll St17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **10-5-43**

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

18 (a) Funeral director

Leonard J. Ruch

(b) Address

5305 Hartford Rd**Huntington Village, Md**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 2 - 1943** at **M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 30 1942** to **Oct 2 1943**; and that I last saw him alive on **Oct 2, 1943**.

Immediate cause of death

Carcinoma of stomach

Duration

1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Lammie M. Ruch

Address

1321 E. North Ave.Date signed **10-4-43****OCT 5 - 1943**

VS 150

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08786
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.*(b) County *Baltimore*(c) City or town *Overlea*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *100 Chesley ave.*

(If rural, give location)

(e) Citizen of foreign country? *No*

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. George Eierman

(JOHN. GEORGE. EIERMAN)

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Anna M. Eierman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 2nd 1866

8. AGE:

Years

Months

Days

*less than one day**77**2**2*

hr.

min.

9. Birthplace

Germany

(town, county, and state)

10. Usual Occupation

Tailor

11. Industry or business

FATHER
MOTHER

12. Name

John George Eierman

13. Birthplace

Germany

14. Maiden Name

Julia Strub

15. Birthplace

Unknown

16 (a) Informant

Miss Edith Eierman

(b) Address

*100 Chesley ave.*17 (a) *Burial*

(b) Date thereof

Oct. 7, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Baltimore, Md.

18 (a) Funeral director

Assessor Funeral Home

(b) Address

7401 Belvoir Road

19 (a)

*OCT 5 - 1943**Huntington Williams, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 7 1943 at 9⁰⁰ A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *9/28 1943* to *10/1/1943*and that I last saw him alive on *10/1/1943*

Immediate cause of death

*Respiratory*** Cardiovascular**Collapsus*

Due to

Peritonitis

Due to

Perforated Caecum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

9/28/43

Major findings of operations

*Perforated**Caecum Ulcer*

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Charles V. Emery

Address

Bon Secours Hosp

Date signed

10/5/43

Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G 08787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08787
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rev. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 23-43

8. AGE: Years

Months

Days

If less than one day

2.

11

hr

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Tarrett Adams.

13. Birthplace

W. Va.

14. Maiden Name

Maria Robertson

15. Birthplace

W. Va.

16 (a) Informant

Reverend

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Removal

(b) Date thereof

Sept 5-43

(c) Cemetery or crematory

Clay W. Va

Location

West Virginia

18 (a) Funeral director

William Book Inc.

19 (a)

OCT 5-1943

(b) (Date rec'd by registrar)

Huntington, West Virginia

2. USUAL RESIDENCE OF DECEASED:

(a) State md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1534 Fleet St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 4

1943

PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1943 to Oct 4 1943, and that I last saw him alive on Oct 4 1943.

Immediate cause of death

diarrhea, acute dehydration

acute

Duration

1 day

Due to

Due to

Other Conditions

chronic diarrhea

2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Johns Hopkins Hospital

23. Signature

Address

C Lee Reader MD

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 BG 08788

Medical Arts Bldg

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2528 E. Preston St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2528 E. Preston St

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

John V. Hubert

3 (b) If veteran, name war

1st. World War

3 (c) Social Security Account

No.

Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Barbara B. Hubert

6 (c) If alive, give age

50 years

7. Birth date of deceased (mo., day, yr.)

Oct. 14, 1887

8. AGE:

Years

Months

Days

If less than one day

55

11

19

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Auto Mechanic

11. Industry or business

12. Name

John V. Hubert

13. Birthplace

Baltimore

14. Maiden Name

Margaret Huber

15. Birthplace

Baltimore

16 (a) Informant

Barbara B. Hubert

(b) Address

2528 E. Preston St

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

10-7-43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore Md

18 (a) Funeral director

Frank Brachman

(b) Address

900 N. E. Street

19 (a)

Registered by

William J. Williams

Oct 5 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 3,

1943, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended

deceased from 7/6/43 to 10/3/43

and that I last saw him alive on Oct 2, 1943

Immediate cause of death

Uremia

Duration

Due to

Carcinoma of bladder

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Charles S. Levy

M. D.

Address

115 Medical Arts Bldg

Date signed 10/4/43

CHARLES S. LEVY

G 08789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08789

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 5319 Gwynn Oak Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5319 Gwynn Oak Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

William W. Frank

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Florence V. Frank

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 29, 1867

8. AGE: Years Months Days If less than one day

76

5

4

hr.

min.

9. Birthplace Chestnut Ridge, Balto. Co., Md.

(Town, county, and state)

10. Usual Occupation Shoe-maker

11. Industry or business Self

12. Name George Frank

13. Birthplace Maryland

14. Maiden Name Kate Kroger

15. Birthplace Germany

16 (a) Informant Miss Martha A. Frank

(b) Address 5319 Gwynn Oak Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 7, 1943

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cemetery

Location

Woodlawn, Md.

18 (a) Funeral director

(b) Address 4510 Liberty Heights Ave.

19 (a)

(Date of registration)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1943, at 11.05 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9/4/43 to 10/3/43
and that I last saw him alive on 10/3/43Immediate cause of death Coronary
OcclusionDuration
30 min.

Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. V. Harper

M. D.

Address 5201 Gwynn Oak Ave. Date signed

CT 5-1943

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08790

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08790

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1413 Light St.*

(c) Hospital or institution:

South Baltimore Pulmonary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 yr.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1510 Chesapeake Ave.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Frances YOUNGBAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 12 - 1943*

8. AGE: Years Months Days If less than one day
- - 23 hr. min.

9. Birthplace *Baltimore Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *William O. Youngbar*

13. Birthplace *Baltimore, Md.*

14. Maiden Name *Helen R. Jacoby*

15. Birthplace *Baltimore, Md.*

16 (a) Informant *William O. Youngbar*

(b) Address *1510 Chesapeake Ave.*

17 (a) *Burial* (b) Date thereof *10-6-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Glen Haven*

Location *G. G. Co. Md.*

18 (a) Funeral director *Flynn & Flynn*

(b) Address *1426 Light St.*

19 (a) *5* 1943
(Date) (year)

(b) *Huntington Williams, M.D.*
Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 5, 1943, at 7:22 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 4, 1943* to *Oct. 5, 1943* and that I last saw her alive on *Oct. 5, 1943*.

Immediate cause of death

Acute gastro-enteritis

Due to

Due to

Other Conditions

Dysentery of palate
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Paul H. Lusk* M. D.

Address *1213 Light St.* Date signed *10-5-43*

G 08791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08791

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *502 Bane St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Eddie Silver

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 9, 1912*

8. AGE: Years Months Days If less than one day

10

25

hr.

min.

9. Birthplace

Suffolk, Va.

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name

Eddie Silver

13. Birthplace

Littleton, N.C.

14. Maiden Name

Mae Peterson

15. Birthplace

Macon, N.C.

16 (a) Informant

Mae Silver

(b) Address

502 Bane St

17 (a) *Burial*
(Burial, cremation, or removal)(b) Date thereof *Oct 7, 1943*
(month), (day) (year)

(c) Cemetery or crematory

Mount Zion

Location

Baltimore County

18 (a) Funeral director

Joseph A. Swick

(b) Address

409 W Mount Street

19 (a) (Date of death)

OCT 5 1943

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 4* 19 *43*, at *9 02* P. M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from *Sept 29* 19 *43* to *Oct 4* 19 *43*,
and that I last saw him alive on *Oct 4* 19 *43*.

Immediate cause of death

Bronchopneumonia

Duration

Due to *Childhood T.B.*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *W. B. Bonfield*Address *Providence Hospital* Date signed *10-5-43*

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 08792

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08792
Registered No. 109726

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore

(c) City or town Catonsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5 Magruder Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace Woodlawn, Md.

(Town, county, and state)

10. Usual Occupation Retired State Employee

11. Industry or business

FATHER
MOTHER

12. Name Charles Schaible

13. Birthplace unknown

14. Maiden Name Georgtanna Macken

15. Birthplace unknown

16 (a) Informant Mrs. Margaret Schaible

(b) Address

17 (a) Burial (b) Date thereof 10/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cem.

Location Randallstown, Md.

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto., Md.

OCT 6 1943

(Date rec'd by Registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/43 19 at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1943 to 10/4/43

and that I last saw him alive on 10/4/43 19

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertensive

Cardio Vascular disease

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. J. Tickner M.D.

Address St. Agnes Hosp Date signed 10/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08793

PLACE OF DEATH:

Baltimore City, Maryland

Street address 285 S. Hamburg St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 285 S. Hamburg St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

William D. Hoover

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-14-3667

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 5 1892

8. AGE:

Years

Months

Days

If less than one day

60611128

hr.

min.

9. Birthplace

S. C.

(Town, county, and state)

10. Usual Occupation

Seaman Old Bay Line

11. Industry or business

Steam ship Co

FATHER

12. Name

Hoover

13. Birthplace

S. C.

MOTHER

14. Maiden Name

Martha Charis

15. Birthplace

S. C.

16 (a) Informant

Bennie West

(b) Address

221 E Churchhill St

17 (a)

Burial

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Glen Haven

Location

Glen Burnie

18 (a) Funeral director

William M. Marek

(b) Address

715 E. 5th St

19 (a)

OCT 6 1943(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-3-1943 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Waldo

M.D.

Medical Examiner.

Date signed 10-4-43

08794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 08794

66962

ya

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **4940 Eastern Avenue**
 (c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) **2 yrs. 3 mos. 8 days.**
 (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
 (c) City or town **Balto.**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **No Home**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Pedrick, Lottie

3 (b) If veteran, name war

3 (c) Social Security Account No. **?**4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or divorced. **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **12/8/1876**

8. AGE: Years **66** Months **9** Days **27** If less than one day
 hr. min.

9. Birthplace **Maryland**

(Town, county, and state)

10. Usual Occupation **None**

11. Industry or business

12. Name **John Pedrick**13. Birthplace **Penn.**14. Maiden Name **Elizabeth Wills Lousen**15. Birthplace **Md.**16 (a) Informant **BALTIMORE CITY HOSPITALS**(b) Address **(RECORDS)**17 (a) **Burial** (b) Date thereof **Oct 7, 1943**

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Western**

Location

18 (a) Funeral director **John C. B. M. Water**(b) Address **Pratt & Stricker St**19 (a) **OCT 6 1943** **Huntington Williams, M.D.**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **10/5** 19 **43** at **1:30 A**

21. I certify that death occurred on the date above stated; that I attended deceased from **7/1** 1943, to **10/5** 1943 and that I last saw her alive on **10/5** 1943.

Immediate cause of death

Acute pneumoniaDue to **Tracheobronchitis of femur. Left**

Due to

Other Conditions **A.S.C.U. disease; Left hemiplegia**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **No post**

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide **Accident**(b) Date of occurrence **Sept 9, 1943** at **M**(c) Where did injury occur? **Baltimore C. H. Hosp** (City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? **hospital** While at work? **No**(e) Means of injury **Fall out of bed**23. Signature **E. L. Seymour**Address **10 C H**Date signed **10/5**

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Approved: **Robert Lee Graham M.D.**

08795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08795
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 W. Rogers Ave.

(c) Hospital or institution:

Home for Aged of Methodist Church(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2211 W. Rogers Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Bell

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1854

8. AGE: Years Months Days If less than one day

89122

hr.

min.

9. Birthplace Greensburg, Penna.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Thomas Bell13. Birthplace England14. Maiden Name Maria Jones15. Birthplace England16 (a) Informant Marion O. Carter, Dupl.(b) Address 2211 W. Rogers St.17 (a) Burial (b) Date thereof 10/6/43
(Burial, cremation, or other disposal) (month) (day) (year)(c) Cemetery or crematory Mt. OlivetLocation Balto. Md.18 (a) Funeral director William Cook Inc.(b) Address 1217 St. Paul St.19 OCT 6 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1943, at 12:30 A.21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death wereIMMEDIATE CAUSE OF DEATH mitral insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Grattan M.D.Date signed October 4, 1943
Medical Examiner.

08796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 08796

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Frances K. Koelbel

3 (b) If veteran, name war

N

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-17-17

8. AGE:

Years

Months

Days

If less than one day

26

4

17

hr

min.

9. Birthplace

Balto

Md

(City, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

at home

12. Name

James L. Dobson

13. Birthplace

Balto Md

14. Maiden Name

Catherine Kelly

15. Birthplace

Balto Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodland Park

Location

Parkville Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

217 St. Paul St.

19

OCT 6

1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3525 Esther Pl.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 4

1943

at 3:20 A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1943 to Oct 4 1943,

and that I last saw her alive on Oct 4 1943

Immediate cause of death UREMIA

Due to

Pyelonephritis, acute and chronic

Due to

Kidney + ureteral stone

Other Conditions

Operative Absence Right Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Philip P. Stapleton, Jr.

Address Johns Hopkins Hospital

Signed 10-4-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08797
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) City or town Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Jessie Wagner

3 (b) If veteran, name war

N

3 (c) Social Security Account

No.

1101E

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 - 1892

8. AGE: Years Months Days If less than one day
51 57 25 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Mary Cox

13. Birthplace Md.

14. Maiden Name Mary Barron

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director William Cook

(b) Address 1217 St. Paul St

19 OCT 6 - 1943 (b) Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1943, at 9:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1943 to 10/5 1943, and that I last saw her alive on 10/5 1943.

Immediate cause of death
Bronchopneumonia
Due to cerebral hemorrhage &
hemiparesis, left.
Due to H.C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Sargman
Address 1854 Date signed 10/5

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address #17 J. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. #17 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

- 3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____

- | | | |
|--|----------------------------------|---|
| 4. Sex
<i>Male</i> | 5. Color or race
<i>White</i> | 6 (a) Single, married, widowed, or divorced
<i>Married</i> |
| 6 (b) Name of husband or wife
<i>Amelia</i> | | 6 (c) If alive, give age years |

7. Birth date of deceased (mo., day, yr.) 1863
8. AGE: Years Months Days If less than one day
 80 hr. min.

9. Birthplace Russia
(Town, county and state)
10. Usual Occupation Retired Tailor
11. Industry or business

- | | | |
|--------|-----------------|---------------|
| FATHER | 12. Name | Meyer Diamond |
| | 13. Birthplace | Russia |
| MOTHER | 14. Maiden Name | Rose |
| | 15. Birthplace | Russia |

- 16 (a) Informant Lonely Diamond
(b) Address #17 N. Milton Ave.

- 17 (a) Burial (b) Date thereof 10-6-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Helen Friendship
Location Waltham + Goshen Sts.

- 18 (a) Funeral director *Jack Louis Inc.*
(b) Address *2100 Eastway Place*
CT 6 1943 *Huntington, Williams, M.D.*
(Data rec'd from registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1943, at 7 P. M.
21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Jan 21st 1942 to Oct 4th 1943,
and that I last saw him alive on Oct 4th 1943

Immediate cause of death.

Cardio Vascular
Diseases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:
- (a) Accident, suicide, or homicide _____
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
- (e) Means of injury _____
23. Signature *H. J. T. Smith*
- Address *100 N. Mulberry* Date signed *12/13/74* M. D.

Duration

8

PHYSICIAN

Underline the cause to which death should be charged statistically.

799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137a Registered No. 8799

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Monument St. Rutland Ave
Sinai Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

3 (a) FULL NAME

Isaac Sternberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Masha Sternberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE:

Years

Months

Days

If less than one day

hr. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

David Sternberg

13. Birthplace

Russia

14. Maiden Name

15. Birthplace

Russia

16 (a) Informant

David Sternberg

(b) Address

1801 N. Pulaski St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10-6-43

(c) Cemetery or crematory

Hew Rose Dale

Location

Pho Rd.

18 (a) Funeral director

Jace Lewis Inc

(b) Address

1434 E. Balto. Rd

OCT 6 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

1801 N. Pulaski St

(e) Citizen of foreign country?

(If rural give location)

(f) If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 5 1943 at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1943 to 10/5 1943, and that I last saw him alive on 10/5 1943

Immediate cause of death

Pulmonary

Edema

myocardial

Insufficiency

Due to

Atherosclerotic Cardio

Vasc. Disease

Due to

Other Conditions

Benign Prostatic

Hypertrophy

Prostatic Calculi

(Include pregnancy within 3 months of death)

Date of operation

8/31, 9/3, 9/13

Major findings of operations:

B.P.H.

Prostatic Calculi, Prostatitis

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

Raymond B. Holding

23. Signature

Sinai Hospital

Address

Date signed 10/5/43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G08800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08800
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County

(c) City or town Pensacola

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

30 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-28-43

1943, at 10 A. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Found Drowned.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

7:20 A.

3/2 M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work?

No?

(d) Means of injury

23. Signature

Howard J. Walden

M.D.

Date signed

9-28-43

Medical Examiner.

OCT 6 1943

VS 151

G 08801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08801
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2024 N. Wolfe St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

LUCY ELIZABETH KLEIN

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Gustav H. Klein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1889

8. AGE: Years Months Days If less than one day

54

1

4

hr.

min.

9. Birthplace Balt., Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John B. Johanson

13. Birthplace Sweden

MOTHER

14. Maiden Name Johanna Schulenberg

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Gustav H. Klein

(b) Address 2024 N. Wolfe St.

17 (a) Burial (b) Date thereof 10/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1649 E. North Ave.

19 (a)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1943, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1943, to 10/4 1943,

and that I last saw her alive on 10/4 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

1 day

Due to

Hypertension

Due to

Coronary vascular disease

7 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address Md. Genl. Hosp. Date signed 10/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 8 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08802
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Redwood & Sun*
(c) Hospital or institution: *V. Univ. Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2*
(e) Length of stay in Baltimore (yrs., mos., or days) *17 1/2*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1315 Myrtle Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Carmi Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *Black* 6 (a) Single, married, widowed, or divorced *married*
6 (b) Name of husband or wife *Leonard Johnson*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *DEC 5 - 1899*

8. AGE: Years *43* Months *10* Days *-* If less than one day *hr* min.

9. Birthplace *Palm Beach Florida*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Alfred Garnu*

13. Birthplace *78*

14. Maiden Name *Harriet Johnson*

15. Birthplace *va*

16 (a) Informant *Leonard Johnson*

(b) Address *1315 Myrtle Ave*

17 (a) *Burial* (b) Date thereof *OCT 8 - 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Calvary*

Location *A. G. Co*

18 (a) Funeral director *Samuel Chase*

(b) Address *638 N. E. 1st St*

19 (a) *OCT 6 1943*
(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/5* 19*43*, at *10:00 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/3* 19*43* to *10/5* 19*43*, and that I last saw him alive on *10/5* 19*43*.

Immediate cause of death

Respiratory failure

Due to *Intracranial hemorrhage*

Due to

Other Conditions *Chronic Hypertension;*
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Frederick J. Williams*
Address *University Hospital* Date signed *10/5-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

THESE PRINTS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08803
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *810 W 34th St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *13*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.*

(b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *810 W 34th St.*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Florence Robbins Simkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female white

widow.

6 (b) Name of husband or wife

Joseph W.

(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

Jan 13, 1878

8. AGE: Years

Months

Days

If less than one day

65

8

22

hr.

min.

9. Birthplace

Pennsgrove, N. J.

(town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name *Joseph A. Robbins.*

13. Birthplace *N. J.*

14. Maiden Name *Sophia Hoffman.*

15. Birthplace *N. J.*

16 (a) Informant *Samuel H. Simkins.*

(b) Address *810 W 34th St.*

17 (a) *Burial*

(b) Date thereof *OCT 7/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Meadowridge*

Location *Ward, Tolrd.*

18 (a) Funeral director *Chenoweth & Donovan*

(b) Address *3615-17 Chestnut Ave.*

OCT 6 1943

(b) *Huntington Williams, M.D.*

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 5, 1943 at 10.5 A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 14 1942* to *Oct 5 1943*, and that I last saw him alive on *Oct 4 1943*.

Immediate cause of death

Myocardial Infarction

Due to

Due to

Calcium & Strontium

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. D. Smith

M. D.

Address *8429 Chestnut Ave.*

Date signed *Oct 5 43*

08804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08804
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 606 W. 36th St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 606 W 36th St.(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles E. Zimmerman

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1895

8. AGE: Years 47 48 Months 10 Days 1 If less than one day hr. min.

9. Birthplace Pa

(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

12. Name Sherman Albert

13. Birthplace Pa.

14. Maiden Name Kitty Staller

15. Birthplace Pa

16 (a) Informant Charles E. Zimmerman

(b) Address 606 W 36th St.17 (a) Burial (b) Date thereof Oct 7/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Chenoweth & Donovan

(b) Address 3615-17 Chestnut Ave

19 OCT 6 1943 Registrar William M. P.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1943, at 4³⁰ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940, to Oct 4 1943, and that I last saw him alive on Oct 4 1943.

Immediate cause of death

Myocardial infarction (acute)

Due to Coronary thrombosis

Due to Cardiac - vascular malformation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Traudman Date signed Oct 4/43

Duration 2 hrs.

10 hrs.

10 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08805
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Belvedere Hotel*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *11*(e) Length of stay in Baltimore (yrs., mos., or days) *Lifetime*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)(d) Street No. *Belvedere Hotel*
(If rural give location)(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry E. Mayer

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

*Male**White**Married*6 (b) Name of husband or wife *Linda M. Mayer*6 (c) If alive, give age *Years*7. Birth date of deceased (mo., day, yr) *Nov. 23, 1868*8. AGE: Years *74* Months *11* Days *13* If less than one day
hr. min.9. Birthplace *Balt. Md.*

(Town, county, and state)

10. Usual Occupation *Turnover Store*11. Industry or business *Eyes.*12. Name *Elias Mayer*13. Birthplace *Unknown*14. Maiden Name *Rachel Elise*15. Birthplace *Unknown*16 (a) Informant *Mrs. Linda M. Mayer*(b) Address *Belvedere Hotel*17 (a) *Burial* (b) Date thereof *10/2/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematorium *Balt. Hebrew*
Location *Balt. Md.*18 (a) Funeral director *David Sonenstein & Son*(b) Address *1902 Eastern Pk.*OCT 6 1943
(D. H. Williams, Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 5 1943 2:55 P M*21. I certify that death occurred on the date above stated; that I attended deceased from *June 26 1943* to *Oct 5 1943*, and that I last saw him alive on *Oct 5 1943*.

Immediate cause of death

Myocardial failure + uremia

Due to

*Cerebral hemorrhage*Due to *(June 26, 43)*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *J. Frederick Leitz*Address *Temple Garden apt* Date signed *Oct 5, 43*

Duration

*10 days**3 1/2**for June 43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

08806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08806
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Fayette & Calton St*
 (c) Hospital or institution: *Franklin Square Hosp.*
 (d) Length of stay in hospital or inst. *12* yrs., mos., or days
 (e) Length of stay in Baltimore (yrs., mos., or days) *2 mos.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *712 Light St., Balto.*
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME *Leif Davis*

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *M.* 5. Color or race *W.* 6 (a) Single, married, widowed, or divorced *S*

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 31 1943*
 8. AGE: Years Months Days If less than one day
2 4 hr. min.

9. Birthplace *Baltimore*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Charles Davis*
 13. Birthplace *Ohio*

14. Maiden Name *Betty Davis*
 15. Birthplace *Ohio*

16 (a) Informant *Mr. Charles E. Davis*
 (b) Address *712 Light St*

17 (a) *Burial* (b) Date thereof *10/8/43*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Green Lawn*
 Location *Portsmouth Ohio*

18 (a) Funeral director *William M. Marek*
 (b) Address *715 Light St*

19 (a) (b) *Huntington Williams, M.D.*
 (Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 5, 1943* at *9:00 A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 4, 1943* to *Oct. 5, 1943*, and that I last saw him alive on *Oct. 5, 1943*.

Immediate cause of death

Malnutrition

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury *H.P. Friedman*

23. Signature *H.P. Friedman* M.D.
 Address *1317 Light St* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

OCT 8 1943

08807

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08807

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Vincent Gentile (Father)

(b) Address 914 Fawn St.

17 (a) Burial (b) Date thereof Oct. 9 - 1943

(c) Cemetery or crematory Holy Redeemer

(b) Address 52 N. Morley St.

18 (a) Funeral director Frank Della Rose

(b) Address 52 N. Morley St.

19 (a) Date of death OCT 6 1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country? (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08808

08808

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 114 S. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County Bartlesville
(c) City or town Bartlesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Barbara Stadler, Stadler, Stadler

3 (b) If veteran, name war

3 (c) Social Security Account No. MOA

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife Bernard 6 (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) August 14, 1875
8. AGE: Years 68 Months 1 Days 17 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Valentine Spiegel
13. Birthplace Germany
MOTHER 14. Maiden Name Margaret Reinlein
15. Birthplace Germany

16 (a) Informant Bernard Stadler
(b) Address 114 S. Madison St

17 (a) burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 13614 Rd.

18 (a) Funeral director M. W. E. Dippels Sons
(b) Address 1000 1/2 N. 1st St.

19 (a) 6 1943 (b) Washington Williams
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1943, at 5:25 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were: Coronary Thrombosis
IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?
(d) Means of injury _____

23. Signature Robert Lee Graham M.D.
Date signed October 5, 1943
Medical Examiner.

G 08809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08809
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John Stevens

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1890

8. AGE:

Years

Months

Days

If less than one day

53

hr.

min.

9. Birthplace

Ky

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

CARTER STEVENS

13. Birthplace

14. Maiden Name

CERESA JOHNSON

15. Birthplace

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a)

removal

(b) Date thereof

10/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ashland, Ky.

Location

Lazer Funeral Home

18 (a) Funeral director

M. W. R. Dippel's Sons

(b) Address

Lombard & Ann St.

19 (a)

OCT 6 1943

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1512 E BALTIMORE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct - 4

1943

at 420 A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1943 to Oct 4 1943, and that I last saw him alive on Oct 4 1943.

Immediate cause of death

Cardiac Failure

Due to

Pneumococcal Pneumonia

Type III

Due to

Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. H. Harnel

Address Johns Hopkins Hosp.

Date signed 10/8/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08810

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) Registrar

(b) Date

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08811

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **3411 EAST LOMBARD ST.**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **LIFE**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County **BALTO.**
 (c) City or town **BALTIMORE**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **3411 EAST LOMBARD ST.**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

CATHERINE NEWBERGER

3 (b) If veteran, name war

NO

3 (c) Social Security Account

NO

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED6 (b) Name of husband or wife **JOSEPH NEWBERGER**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **APR. 7 1869**

8. AGE: Years Months Days If less than one day

74 5 27 hr. min.9. Birthplace **BALTIMORE MD.**

(Town, county, and state)

10. Usual Occupation **HOUSE WIFE**11. Industry or business **AT HOME**12. Name **JOHN SPRINK**13. Birthplace **BALTO. MD.**14. Maiden Name **ELIZABETH KOCH**15. Birthplace **BALTO. MD.**16 (a) Informant **JOSEPH NEWBERGER (HUSBAND)**(b) Address **3411 E. LOMBARD ST.**17 (a) **BURIAL** (b) Date thereof **OCT. 7/43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **HOLY REDEEMER**Location **BELAIR ROAD**18 (a) Funeral director **Lilly and Guter INC.**(b) Address **403 S. WOLFE ST.**19 (a) **OCT 6 1943** (b) **1943**

(c) **1943**
 (d) **1943**
 (e) **1943**

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT. 4 1943 at 10 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 1939** to **OCT 4 1943**, and that I last saw him alive on **OCT 4 1943**

Immediate cause of death

myocardial degeneration

Due to

arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **John J. Gould** M. D.Address **142 East Ave** Date signed **10-5-43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08812

BALTIMORE CITY HEALTH DEPARTMENT

G 08812

T.N

82926

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **2940 Eastern Ave**
 (c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) **2 months**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) **Maryland** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **608 S. Hanover St**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Charles Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or divorced
Widower

6 (b) Name of husband or wife

Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb 16, 1880**8. AGE: Years **63** Months **7** Days **15** If less than one day hr. min.9. Birthplace **Maryland**

(Town, county, and state)

10. Usual Occupation **Unemployed**

11. Industry or business

12. Name **H. W. Richards**13. Birthplace **Maryland**14. Maiden Name **Elizabeth Goddard**15. Birthplace **Maryland**16 (a) Informant **Baltimore City Hospitals**(b) Address **4940 Eastern Ave**

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location **UNIVERSITY MEDICAL SCHOOL OCT 6 1943**18 (a) Funeral director **Commissioner of Health**

(b) Address

19 (a) **OCT 6 1943** (b) **Huntington Williams, M.D.**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 1 1943** at **10:00 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **July 29 1942** to **Oct. 1 1943** and that I last saw him alive on **Sept 20 1942**.

Immediate cause of death

Autonomous embolismDue to **thrombosis of right femoral vein**Due to **Legionnaire's disease**Other Conditions **Depressed Ventral hernia**

(Include pregnancy within 3 months of death)

Date of operation **Oct 4 - 1943**Major findings of operation **Ventral hernia - Varicose veins**

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **J. S. P. P. P.**Address **Baltimore City Md** Date signed **Oct 6 1943**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08813

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2703 Barclay St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 15 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2703 Barclay St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

HUBERT Kenneth BENSON

3 (b) If veteran, name war

3 (c) Social Security Account

No. 232-24-0944

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December ? 1920

8. AGE:

Years

Months

Days

If less than one day

22

10

hr.

min.

9. Birthplace Terra Alta, W. Va.

(Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Bethlehem-Fairfield Ship Yards

FATHER
MOTHER

12. Name Arthur Benson

13. Birthplace United States

14. Maiden Name Ida ?

15. Birthplace United States

16 (a) Informant Mrs. Josephine Bobo

(b) Address 2703 Barclay St.

17 (a) Removal (b) Date thereof Oct. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Terra Alta, W. Va.

18 (a) Funeral director E. W. Ramonau

(b) Address 1005 W. Baltimore St.

19 OCT 6 1943

(Date rec'd by Registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1943, at 6:15 PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inspection thereon and from the evidence

(Autopsy or Inquiry)

obtained by said find that said deceased came

(Autopsy or Inquiry)

to his death on the day stated above.

Immediate cause of death

Typhoid poisoning

Duration

Due to

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide suicide

(b) Date of occurrence 10-5-43

at 6:15 PM

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work?

(Specify type of place)

(e) Means of injury Typhoid

23. Signature H. L. Williams, M.D.

M.D.

Date signed 10-5-43

G 08814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08814

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2329 E. Federal St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days):

3 (a) FULL NAME

Louis C. Lomp

3 (b) If veteran, name war

3 (c) Social Security Account

No. 717-07-8223

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Helene C. Lomp6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

July - 20 - 1892

8. AGE: Years

Months

Days

51215

hr.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual Occupation

Conductor

11. Industry or business

Penn. R.R.FATHER
MOTHER

12. Name

John Lomp

13. Birthplace

Germany

14. Maiden Name

Anna Tripp

15. Birthplace

Germany

16 (a) Informant

Helene C. Lomp

(b) Address

2329 E. Federal St

17 (a)

Burial
(burial, cremation, or removal)

(b) Date thereof

10-8-43
(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd. Balto. Md.

18 (a) Funeral director

John C. Miller Inc.

(b) Address

2329 E. Federal St

19 (a)

October 4, 1943
(Date rec'd by registrar)

(b)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 E. Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1943, at 7 45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature

Robert L. Gutman

M.D.

Date signed

October 5 1943

8815

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

G 08815

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 4940 Eastern Ave.
 (c) Hospital or institution:
 Baltimore City Hospitals
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 101 ds
 (e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1311 Central Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME Moses McGee 82263

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex male 5. Color or race black 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1926

8. AGE: Years 17 Months 7 Days 18 If less than one day hr. min.

9. Birthplace N.C.
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas McGee
 13. Birthplace N.C.
 MOTHER 14. Maiden Name Belle Hampton
 15. Birthplace N.C.

16 (a) Informant Hospital records
 (b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/7/43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory
 Location Danville Va.

18 (a) Funeral director Elroy O. Wilson
 (b) Address 1000 Brantley Ave.

19 (a) OCT 6 1943
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 19 43 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 19 43 to Oct. 4 19 43, and that I last saw him alive on Oct. 4 19 43

Immediate cause of death

Pulmonary tuberculosis 6 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Hatt

Address Scr

Date signed 10/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08816

BALTIMORE CITY HEALTH DEPARTMENT

G 08816

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943, to Oct 6 1943, and that I last saw him alive on Oct 6 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08817

441311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08817

Registered No.

54a

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.J. (b) County

(c) City or town Atlantic City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 61 N. 10th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Leon Evan Fair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7/12/06

8. AGE:

Years

Months

Days

If less than one day

37

2

24

hr.

min.

9. Birthplace

N.J.

(Town, county, and state)

10. Usual Occupation

Carpenter

11. Industry or business

12. Name

John Fair

13. Birthplace

Md.

14. Maiden Name

Emma Jeffries

15. Birthplace

N.J.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

10/6/43

(month) (day) (year)

(c) Cemetery or crematory

Zion Cem.

Location

Atlantic City, N. J.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 OCT 7 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 6

1943 at 9:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Oct 6 1943 and that I last saw him alive on Oct 6 1943.

Immediate cause of death

Brain tumor - malign -
metast

Duration

3 yrs?

Due to

Due to

Other Conditions

Chronic pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Glioma

of autopsy

in situ
not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

J. G. OTENOSCH

Date signed

M. D.

10-6-43

G 08818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08818
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

Johns Hopkins General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 657 Light St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Emory Harper

3 (b) If veteran, name war

3 (c) Social Security Account

No. 225-10-5687

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Virginia E

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct 3 1907

8. AGE: Years

35 36

Months

11

Days

28

If less than one day

hr.

min.

9. Birthplace

W Va

(Town, county, and state)

10. Usual Occupation Electrician Md Dry Dock

11. Industry or business

12. Name Henry N Harper

13. Birthplace

W Va

14. Maiden Name Tillie B James

15. Birthplace

W Va

16 (a) Informant Mrs Virginia E Harper

(b) Address 657 Light St

17 (a) Removal (Burial, cremation, or removal)

(b) Date thereof 10/6/43

(month) (day) (year)

(c) Cemetery or crematory

Location Falmouth W Va

18 (a) Funeral director William M Marek

(b) Address 713 Light St

19 (a) (Date rec'd by registrar)

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1943, at 1:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1943 to Oct 3 1943, and that I last saw him alive on Oct 3 1943.

Immediate cause of death Bronchopneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Paul H. Lukats

M. D.

Address 1213 Light St Date signed 10-4-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08819

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1400 N. Caroline St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

BABY BOY PLEINES (A)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 23rd 1943

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Charles Pleines

13. Birthplace

Md

MOTHER

14. Maiden Name

Thelma Abbott

15. Birthplace

Md

16 (a) Informant

Mrs Thelma Pleines

(b) Address

2328 E. Hoffman St

17 (a)

Burial

(b) Date thereof

10/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Baltimore

Location

Md.

18 (a) Funeral director

William Bok Inc

(b) Address

127 St. Paul St.

19

OCT 7 1943

(Date rec'd by registrar)

Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 6 1943 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1943 to 10-6 1943, and that I last saw him alive on 10-6 1943.

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

Md

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. B. Belline, M.D.

Address

St. Joseph's Hosp. Date signed 10/6/43

G 08820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08820
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 334 H.

(c) Hospital or institution:

Union Memorial Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Wilson M. Cary.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

D.

6 (b) Name of husband or wife HELEN LANAHAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1880.

8. AGE: Years

Months

Days

If less than one day

62

9

12

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

Md

10. Usual Occupation Manufacturer - retail.

11. Industry or business

none.

FATHER

12. Name John Bruce Cary

13. Birthplace Baltimore

MOTHER

14. Maiden Name Daniel (Frances)

15. Birthplace Charles Town W. Va.

16 (a) Informant Mrs. Jacob A. Ullman

(b) Address 1418 Park Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct 8 43

(Month) (day) (year)

(c) Cemetery or crematory

St. Thomas

Location Garrison Forest Rd

18 (a) Funeral director Henry H. Jenkins, Son

(b) Address 300 Cullum - Orchard St

19 OCT 7 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Balto

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1418 Park Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1943, to Oct. 6 1943, and that I last saw him alive on Oct. 6 1943.

Immediate cause of death

Pulmonary edema

Due to Labor Pneumonia

Due to

Other Conditions Infection

Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature John A. Harrison

Address Union Memorial Hosp

M. D.

Date signed 10-6-43

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 03821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08821

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/7/43 19 at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1943 to 10/7 1943, and that I last saw him alive on 10/7 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

10/7

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 7 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a G 08822
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2427 Reisterstown Road**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **13**
(e) Length of stay in Baltimore (yrs., mos., or days) **40 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2427 Reisterstown Road**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Gussie Leah Ruben

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife

Elias

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1880

8. AGE:

Years **63**

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

FATHER

12. Name

Samuel Jacob Petricer

13. Birthplace

Russia

MOTHER

14. Maiden Name

Etta ?

15. Birthplace

Russia

16 (a) Informant

Elias Ruben

(b) Address

2427 Reisterstown Road

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Oct, 6, 1943**

(month) (day) (year)

(c) Cemetery or crematory

Sharrei Tfiloh Cemetery

Location

Windsor Mill Road

18 (a) Funeral director

Sol Levinson & Bros

(b) Address

1124 1126 W North Ave

OCT 7 1943

(Date rec'd by Registrar)

(b) **Huntington Williams, M.D.**

MEDICAL CERTIFICATION

3.40

20. DATE OF DEATH **October 5** 19**43**, at **P.** M.

21. I certify that death occurred on the date above stated; that I attended deceased from **1936** 19 to **Oct 5** 19**43**, and that I last saw him alive on **Oct 5** 19**43**.

Immediate cause of death

acute coronary thrombosis 2 hrs.

Due to

coronary sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams

Address

2904 Reist Rd

Date signed

N/S/43

G 08823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1066

G 08823

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1753 Hammond St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Joseph John Deland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/43

8. AGE: Years 1 Months 76 Days 25 hr 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George J. Deland

13. Birthplace Baltimore, Md.

14. Maiden Name Rose Clements

15. Birthplace Baltimore, Md.

16 (a) Informant George J. Deland

(b) Address 1753 Hammond St.

17 (a) Burial (b) Date thereof 10/7/43

(c) Cemetery or crematory Holy Cross A.C.

Location Maryland Ave.

18 (a) Funeral director

(b) Address 1318 E. Pratt St.

19 (a) 7-1943 (b) Registrar

VS 1

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1753 Hammond St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH - 10/5/43 at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from - Sept 24 1943 to 10/5 1943 and that I last saw him alive on - Oct 3 1943.

Immediate cause of death

- Acute Dehydration of Heart

Due to - Chronic Dehydration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature O. B. Williams

Address 279 William St.

Date signed 10/2/43

Duration

1 day

2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08824
MJ-83458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08824
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. 1 mo., 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Fleet St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Nellie Nelson) Matilda Ellen Nelson

3 (b) If veteran, name war
No

3 (c) Social Security Account
No. 213-05-0281

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1879

8. AGE: Years 64 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Eastern Shore, Maryland
(Town, county, and state)

10. Usual Occupation Sewing machine operator

11. Industry or business Shirt mfg.

12. Name John Nelson

13. Birthplace Maryland

14. Maiden Name Roxy Hitch

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Ellen Fritz

(b) Address 3042 Chesterfield Ave.

17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc

(b) Address North Ave. & Broadway

19 (a) OCT 7 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-1943 11:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15-1943 to 10-5-1943 and that I last saw him alive on 10-5-1943

Immediate cause of death

Due to Bronchopneumonia
Due to Carcinoma of mouth

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Omar B. Webb
Address Baltimore, Md. Date signed 8-9-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

8825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124b

Registered G 8825

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

3104 Normount Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

16

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary E. Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Charles E. Gibbs

6 (c) If alive, give age

65 years

7. Birth date of deceased (mo., day, yr.)

Aug. 30, 1870

8. AGE: Years Months Days

If less than one day

73 72

1

4

hr.

min.

9. Birthplace

New Haven, Conn.

(Town, county, and state)

10. Usual Occupation

Home Duties

11. Industry or business

12. Name

William Clasp

13. Birthplace

Baltimore, Md

14. Maiden Name

Elizabeth Lane

15. Birthplace

Baltimore, Md

16 (a) Informant

Charles E. Gibbs

(b) Address

3104 Normount Ave

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

10-6-43

(c) Cemetery or crematory

Western

Location

Baltimore, Md

18 (a) Funeral director

Friedrich & Co

(b) Address

100 N Lombard St

Date filed by registrar

OCT 7 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3104 Normount Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 4 1943 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from

1941 Oct. 4

1943

and that I last saw alive on Oct. 4 1943

Immediate cause of death

Broncho pneumonia

Duration

10 days

Due to

Due to

Other Conditions

Cirrhosis of liver 2406

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

Means of injury

Signature

W. R. Johnson

Address 403 N. 1st St

Date signed 10-6-43

8826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08826
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Madison St. & Linden Ave*
 (c) Hospital or institution: *Maryland General*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *13 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3302 Deoga Plwy*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

William P Talbott

3 (b) If veteran, name war

3 (c) Social Security Account

No. *216-01-8557*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *May 8, 1905*

8. AGE:

Years

Months

Days

If less than one day

*38**4**28**27*

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Auditor

11. Industry or business

*Brewery*FATHER
MOTHER

12. Name

William M. Talbott

13. Birthplace

Baltimore Md.

14. Maiden Name

Mary Calder

15. Birthplace

Bolton Md.

16 (a) Informant

Mrs. William M. Talbott

(b) Address

5008 Beaufort Ave

17 (a)

Burial

(b) Date thereof

10/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Bolton City

18 (a) Funeral director

C. Vernon Lemmon

(b) Address

4611 Park Heights

19 (a)

OCT 7 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

*10/5**1943 at 3:25 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8/31 1943 to 10/5 1943*, and that I last saw him alive on *10/5 1943*.

Immediate cause of death

Progressive Stenosis

Due to

Bacterial Fistula

Due to

Recurrent Bacterial Ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations

of autopsy: *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John D. Young Jr.

Address

*Maryland General Hospital*Date signed *10/5/43*

G 08827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08827
Registered No.

93d

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3156 Elmora Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3156 Elmora Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

EDWARD S. FERRIN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

WIDOWER

6 (b) Name of husband or wife Susan A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1861

8. AGE: Years 82 Months 2 Days 10
hr. min.

9. Birthplace New Hampshire

(Town, county, and state)

10. Usual Occupation Retired Painter

11. Industry or business Balto. Transit Co.

12. Name Charles Ferrin

13. Birthplace Unknown

14. Maiden Name Charlotte Ward

15. Birthplace Unknown

16 (a) Informant Mr. Victor W. Ferrin

(b) Address 3156 Elmora Ave.

17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. Fickner & Sons

(b) Address Baltimore, Md.

19 (a) OCT 7 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1943, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arterio-sclerotic

cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. Z. Wallenweber M.D.

Medical Examiner.

Date signed 10-6-43

08828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08828
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 5610 Merville Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5610 Merville Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Willie Juliet Leberstein

3 (b) If veteran, name war

--

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife Martin L. Leberstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21, 1904

8. AGE: Years Months Days If less than one day

39

6

13

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Forelady - Retired

11. Industry or business Greenville Mfg. Co.

FATHER

12. Name John Biles

13. Birthplace England

MOTHER

14. Maiden Name Amelia Sweitzer

15. Birthplace Balto.

16 (a) Informant Mr. Martin L. Leberstein

(b) Address 5610 Merville Ave.

17 (a) Burial (b) Date thereof 10/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1943, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug. 23, 1943, to Oct. 4, 1943,
and that I last saw her alive on Oct. 4, 1943.Immediate cause of death Coronary
Occlusion

Duration

1 hour

Due to Coronary Sclerosis

Due to Chronic Nephritis

Other Conditions Myocarditis
Chronic

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury Sherman R. Hantz

23. Signature 2601 Manhattan signed Oct. 5, 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08829

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Marble Hall Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Scott Poole

3 (b) If veteran, name war no
3 (c) Social Security Account No. no

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife. --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1942

8. AGE: Years 1 Months 7 Days 25 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

12. Name William D. Poole

13. Birthplace Troy, N. C.

14. Maiden Name Hazel C. McNair

15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. William D. Poole

(b) Address 4413 Marble Hall Rd.

17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 OCT 7 1943 Stuntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1943 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1943 to 10-6 1943, and that I last saw him alive on 10-6 1943.

Immediate cause of death

Acute lymphoid leukemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Shelham B. Hagan
Address Univ. Hosp. Date signed 10/6/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08830
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Madison + Howard*
 (c) Hospital or institution: *Maryland General Hosp.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *3 hours*
 (e) Length of stay in Baltimore (yrs., mos., or days) *63*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *2004 Edgewood St.*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME

George Barth

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. *164-10-2317*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

*Marion*6 (c) If alive, give age *63* years

7. Birth date of deceased (mo., day, yr.)

Sept 1, 1880

8. AGE: Years *63* Months *2* Days *5* hr. min.

9. Birthplace

Newark, N.J.

(Town, county and state)

10. Usual Occupation

Brick Mfg.

11. Industry or business

12. Name

John Barth

13. Birthplace

Germany

14. Maiden Name

Pauline Volz

15. Birthplace

Germany

16 (a) Informant

Mrs. Marion Barth

(b) Address

2204 Edgewood St.

17 (a) Burial (b) Date thereof

10/9/43

(c) Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18 (a) Funeral director

Wm. J. Tickner & Sons

(b) Address

*Balto., Md.**Oct 7 1943*19 (a) (Date rec'd by registrar) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 6* 1943, at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 6, 1943, to Oct. 6, 1943*, and that I last saw him alive on *Oct. 6, 1943*.

Immediate cause of death *Abdominal**Hemorrhage*Due to *Ruptured varicose*Due to *Hemachromatosis*Other Conditions *Diabetes Mellitus*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: *Ruptured varicose*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *10/6/43* at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *G. Herman Williams*

M. D.

Address *Md. Gen. Hosp.* Date signed*Oct. 6, 1943*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH140 G 08831
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.(b) County Balt.

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

211 W. 29th St.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

Mrs. Elmore Scheffler Wagner

3 (b) If veteran, name war

--

3 (c) Social Security Account

No.

--

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

WIDOW.6 (b) Name of husband or wife George F. Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1889

8. AGE:

Years

Months

Days

If less than one day

5941

hr.

min.

9. Birthplace

New Jersey

(Town, county, and state)

10. Usual Occupation

Housewife.

11. Industry or business

FATHER

12. Name

--

Scheffler

MOTHER

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

"16 (a) Informant Mr. George H. Wagner(b) Address 211 W. 29th St.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/9/43

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn, Md.18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

OCT 7 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1943 at 4:30 M21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1943, to Oct. 6 1943, and that I last saw her alive on Oct. 6 1943.Immediate cause of death Heart and Respiratory failureDue to SEPTICEMIA, STREPT. OCCAL.Due to Respiratory infection

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature John A. RadtkeAddress Union Memorial Hospital M. D. 3-42

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G 08832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08832
94a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 5101 Brook Green Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Brook Green Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARGARET EDITH PLUMLY

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Charles A. Plumly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1874

8. AGE: Years Months Days

69

2

26

If less than one day

hr.

min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph B. Mann

13. Birthplace Ohio

14. Maiden Name Annie Earhart

15. Birthplace Indian Hill, Ohio

16 (a) Informant Mr. Charles A. Plumly

(b) Address 5101 Brook Green Rd.

17 (a) Burial (b) Date thereof 10/9/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.
1943

19 (a) (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1943, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1943, to Oct. 6, 1943, and that I last saw her alive on Oct. 6, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

6 days

Due to Arteriosclerosis and
hypertension & con.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Eugene L. Cavanaugh
Address 514 Drury Lane Date signed Oct. 6, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08833

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace Balto Co. Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 6

19 43, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1943 to 10-6 1943 and that I last saw him alive on 10-5 1943.

Immediate cause of death

Resp. Failure

Duration

Due to

Hypertensive pneumonia

3 day

Due to

Smility, Fracture L. Femur

24 day

Other Conditions

Paralysis agitans

(Include pregnancy within 3 months of death)

Date of operation

9-14-43

Major findings of operation:

Intracerebral Fracture L. Femur

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

Baltimore

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

John A. Herbert

M. D.

Address

Union Manual Home Date signed 10-6-43

Huntington - by Howard J. Madden M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08834

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08834

Registered No.

1336

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 yrs

3 (a) FULL NAME

Richard Chioldi

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1941

8. AGE: Years Months Days If less than one day
2 1 6 hr. min.9. Birthplace Honolulu, Hawaii
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Vincent M. Chioldi

13. Birthplace Baltimore, Md

14. Maiden Name Nancy M. Malloy

15. Birthplace Baltimore, Md

16 (a) Informant Nancy M. Chioldi

(b) Address 512 Dunkirk Rd.

17 (a) Burial (b) Date thereof Oct. 8, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Baltimore, Md

18 (a) Funeral director Glenwood J. Cooney

(b) Address 2614 W. 26th St

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

(Date rec'd by registrar)

(Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(d) Street No. 512 Dunkirk Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1943, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 21, 1943, to Oct 6, 1943

and that I last saw him alive on Oct 6, 1943

Immediate cause of death Respiratory

+ Cardiac Failure Terminal

Due to Anasarca 1 mo

Due to Nephrosis 2 mos

Other Conditions

(Include procedure within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

25. Signature Hugh B. Gower Jr

Address Union Memorial Hosp signed 10/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08835
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 007

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3018 Abell Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME SAMUEL RICHMOND

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Margaret E. Hart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1887

8. AGE: Years Months Days If less than one day

55

10

17

hr.

min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Delivery11. Industry or business Arrow Blowing Co.12. Name Matthew Richmond13. Birthplace Ireland14. Maiden Name Annie Richmond15. Birthplace Maryland16 (a) Informant Mrs. Margaret E. Richmond(b) Address 3018 Abell Ave17 (a) Burial (b) Date thereof 10/9/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood CemeteryLocation Baltimore, Md18 (a) Funeral director H. W. Meardon(b) Address 805 N. Calvert St.19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1943, at 4:30 M21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature H. Z. Wallensten M.D.
Medical Examiner.Date signed 10-6-43

G 08836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08836
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1400 W. Lexington St.

(c) Hospital or institution:

Aged Women's & Men's Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Oliver O. Swallow

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

MALE

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1867

8. AGE: Years

76

Months

Days

If less than one day

hr.

min.

9. Birthplace

Hagerstown, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

John E. Swallow

13. Birthplace

14. Maiden Name

Marcy E. Snyder

15. Birthplace

16 (a) Informant

Aged Women's & Men's Home

(b) Address

1400 W. Lexington St.

17 (a)

Burial

(b) Date thereof

10/5/43

(Burial, cremation, or inquest)

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge

Location

Pikesville, Md.

18 (a) Funeral director

William Cook, Inc.

(b) Address

1217 St. Paul Street

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Maryland

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1400 W. Lexington St.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 5

1943

at 9:45 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 9/22/41 19 to 10/5/43 19

and that I last saw him alive on 10/5/43 19

Immediate cause of death

Fractured skull

Duration

2 hrs.

Due to injury by fall

Due to

Other Conditions

Hypertension.

Generalized arterio-sclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following 9/2

(a) Accident, suicide, or homicide. Accident.

(b) Date of occurrence

10/5/43

at 7:30 P.M.

(c) Where did injury occur?

at home.

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place? at home.

While at work?

No

(Specify type of place)

(e) Means of injury

on hit head by pipe from boiler

23. Signature

William B. Smith

Address 11 E. Chase St., City Date signed 10/6/43

Approved by Howard J. Wallace, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08837

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

Norway

(c) City or town

Sandefjord

(If outside city or town, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Abraham

Abrahamsen

3 (b) If veteran, name war

3 (c) Social Security Account

No.

FIVE

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1906

8. AGE: Years

37

Months

Days

If less than one day

hr.

min.

9. Birthplace

Norway

(Town, county, and state)

10. Usual Occupation

Seaman

11. Industry or business

12. Name

Abraham

13. Birthplace

Norway

14. Maiden Name

Abraham

15. Birthplace

Norway

16 (a) Informant

Norwegian Consul

(b) Address

Baltimore Md

17 (a)

Cremation

(b) Date thereof

10/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Mount

Location

Baltimore Md

18 (a) Funeral director

Huntington Williams, M.D.

(b) Address

314 N. E. St.

OCT 7 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1943 at 3 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of

skull

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10/2/43 at 11:00 P. M.

(b) Where did injury occur Frankfort Avenue

(c) Did injury occur at home, on farm, industrial place, in public

place? public

While at work?

no

(d) Means of injury Struck by hit and run.

23. Signature

Robert L. Graham

M.D.

Signed

Oct. 3 1943

08838

HEALTH DEPARTMENT—CITY OF BALTIMORE

08838

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2454* *Amman* St., *3940* Ward)Length of residence in city or town where death occurred *yr.* *mon.* *ds.* How long in U. S. If of foreign birth? *yr.* *mon.* *ds.*2. FULL NAME *HELE EBLICK BURN*(a) Residence: No. *2454 Amman* *St.* *3940* Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. Color or Race *White* 5. Single, Married, Widowed, or Divorced (write the word) *Single*6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day, year) *Jan 14 1923*7. AGE *20* Years *8* Months *21* Days If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) *Baltimore*13. NAME *James E. Burn*14. BIRTHPLACE (city or town) (State or country) *Baltimore*15. MAIDEN NAME *Helen E. Burn*16. BIRTHPLACE (city or town) (State or country) *Baltimore*17. INFORMANT *Helen E. Burn*
(Address) *2454 Amman St.*

18. BURIAL, CREMATION, OR REMOVAL

Place *St. Anthony's* Date *Oct. 8* 19*43*19. UNDERTAKER *Mrs. Katie R. Williams*
(Address) *322 N. Charles St.*20. FILED *19*

OCT 7 1943

Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *Oct 5 1943*22. I HEREBY CERTIFY, That I attended deceased from *Oct 2* 19*43* to *Oct 5* 19*43*I last saw him alive on *Oct 5 1943* Death is saidto have occurred on the date stated above, *Oct 5 1943*

The principal cause of death and related causes of importance were as follows:

*Concussion of the brain*Other contributory causes of importance: *Coronary artery disease*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19*43*

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *Huntington Williams* M. D.*1000*

OCCUPATION is very important. See instructions on back of certificate.

G 08839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08839

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

Felix Brzozowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1891

8. AGE:

51 52

Months

11

Days

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

FATHER
MOTHER

12. Name

John Brzozowski

13. Birthplace

Poland

14. Maiden Name

unknown

15. Birthplace

Poland

16 (a) Informant Mrs. Ida West

(b) Address 1615 Cypress Street

17 (a) Burial (b) Date thereof Oct 8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary Ceme

Location Baltimore County

18 (a) Funeral director John M. Welbes

Address 4184 S. Chester Street

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1615 Cypress St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1943, 12:50 A

21. I certify that I took charge of the remains described above, held an

Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH One fatal Embolus

spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham

M.D.

Date signed October 5, 1943

08840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

336 08840

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.04

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced

Married

6 (b) Name of husband or wife

Lethal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1911

8. AGE: Years Months Days If less than one day

32⁵ - 19 hr. min.

9. Birthplace

Greenville S. C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

James Schofield

13. Birthplace

S. C.

MOTHER

14. Maiden Name

Carrie Young

15. Birthplace

S. C.

16 (a) Informant

Carrie Schofield

(b) Address 1216 St James St.

17 (a) Burial

(b) Date thereof Oct. 7 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cemetery

Location G. G. County, Md.

18 (a) Funeral director

Mrs Robert A. Elford, Jr.

(b) Address 1129 N. Caroline St.

19 (a)

(Date of Registrar)

OCT 7 1943

(b)

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1216

St. James St

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1943, 9²⁰ P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

chronic

pyelonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert L. Engstrom

M.D.

Medical Examiner

October 2 1943

G 08841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08841
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1435 E. Eager St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *20 yrs.*

3 (a) FULL NAME

Irene Jordan

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

*Charles Jordan Sr.*6 (c) If alive, give age *49* years

7. Birth date of deceased (mo., day, yr.)

May 10, 1896

8. AGE:

Years

Months

Days

If less than one day

*47**4**24*

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Mack Wilkins

13. Birthplace

Va.

14. Maiden Name

Unknown

15. Birthplace

Va.

16 (a) Informant

Charles Jordan Sr.

(b) Address

*1435 E. Eager St.*17 (a) *Burial*

(b) Date thereof

Oct. 7, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arbutus Memorial Park

Location

Arbutus Md.

18 (a) Funeral director

Mrs. Robert A. Elliott & Daughter

(b) Address

1129 N. Caroline Street

19 (a)

OCT 7 1943

(b)

Thurston Williams, Jr.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1435 E. Eager St.*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 7, 1943* at *5:00 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *9-16* 19*43* to *10-4* 19*43* and that I last saw her alive on *10-3* 19*43*

Immediate cause of death

*Hypertensive cardio-vascular disease**Due to**(uremia)*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address *1000 13th Madison St* Date signed *10/8/43**Rayner Browne*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08842

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1827 Argonville St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Frank Wamhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-1-1868

8. AGE:

Years

Months

Days

If less than one day

77

9 10

7 5

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Retired Motorman

12. Name

John Wamhoff

13. Birthplace

Baltimore Md

14. Maiden Name

Gertrude Speckelmeier

15. Birthplace

Germany

16 (a) Informant

Mrs M Wamhoff, Wife

(b) Address

1827 Argonville St

17 (a) Burial

(b) Date thereof

10 9-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral Cemetery

Location

18 (a) Funeral director

May M. Macdowell

(b) Address

501 E. 32nd St

19 OCT 7 1943

Huntington Williams, MD

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore Md

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1827 Argonville St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 6 1943 at 4 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1943 to Oct 6 1943.

and that I last saw him alive on Oct 6 1943.

Immediate cause of death

Cerebral Hemorrhage
arterio sclerosis

Due to

Due to

Other Conditions Cardio Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. Williams

Address 1827 Argonville St

Date signed

10/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08843

The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1712 E. CHASE ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

3 (a) FULL NAME

HYMAN POLASHUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

ESTHER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 68 Months Days If less than one day hr. min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER
MOTHER

12. Name

YECHIAL POLASHUK

13. Birthplace

RUSSIA

14. Maiden Name

MARIAN

15. Birthplace

RUSSIA

16 (a) Informant WIFE

(b) Address

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof 10-7-43

(month) (day) (year)

(c) Cemetery or crematory

MT. CARMEL

Location GERMAN HILL RD

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Balto ST

19 (a) 17 1943

Huntington Williams, MD

VS 166

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1712 E. CHASE ST

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-43 19 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Oct 6, 1943, and that I last saw him alive on Oct 5, 1943

Immediate cause of death

myocardial failure

Duration

Due to

Due to

Other Conditions

Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Jack D. Singer

Address

506 E. North Ave

Date signed 10/7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08844

BALTIMORE CITY HEALTH DEPARTMENT

G 08844

CERTIFICATE OF DEATH

Registered No.

876

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date registered

OCT 7 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-6 1943, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1943 to 10-6 1943, and that I last saw him alive on 10-6 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08845
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

Female

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John F. Stierhoff

7. Birth date of deceased (mo., day, yr.)

May 30, 1885

8. AGE:

Years

Months

Days

If less than one day

58

4

4

hr.

min.

9. Birthplace

Balto. Md.

10. Usual Occupation

H.W.

11. Industry or business

Own Home

12. Name

Oliver Thompson

13. Birthplace

Md.

14. Maiden Name

Unknown

15. Birthplace

Md.

16 (a) Informant

John F. Stierhoff

(b) Address

422 S. Payson St.

17 (a) Burial

Oct. 7/43

(b) Date of removal

(c) Cemetery or crematory

condem Park

Location

Balto. Md.

18 (a) Funeral director

Harry F. Huppel

(b) Address

Edmondson Ave.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

422 S. Payson St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 4/43

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1943 to Oct. 4 1943, and that I last saw her alive on 10/4 1943.

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Benjamin Miller, M.D.

Address

2036 Wilkens Ave

Date signed

10/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3- G 08846		BALTIMORE CITY HEALTH DEPARTMENT		G 08846	
CERTIFICATE OF DEATH				93d Registered No.	
1. PLACE OF DEATH:				2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland				(a) State <i>Md</i> (b) County	
(b) Street address <i>Howard + Linden</i>				(c) City or town <i>Baltimore 29</i> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution: <i>Md. Gen. Hosp.</i>				(d) Street No. <i>833 Brinkwood Rd</i> (If rural give location)	
(d) Length of stay in hospital or inst. (<i>2</i> mos., or <i>2</i> yrs.)				(e) Citizen of foreign country? <i>No</i> (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days) <i>86 yrs</i>				If yes, name country	
3 (a) FULL NAME <i>Samuel M. Elder</i>					
3 (b) If veteran, name war			3 (c) Social Security Account No.		
4. Sex <i>M</i>	5. Color or race <i>W</i>	6 (a) Single, married, widowed, or divorced. <i>Widowed</i>			
6 (b) Name of husband or wife <i>late Georgia</i>					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) <i>Sept 21, 1873</i>					
8. AGE: Years <i>70</i> Months <i>-</i> Days <i>16</i> Less than one day hr. min.					
9. Birthplace <i>O. Ohio</i> (Town, county, and state)					
10. Usual Occupation <i>Lumber Agent</i>					
11. Industry or business <i>B & O. R.R.</i>					
12. Name <i>James Elder</i>					
13. Birthplace <i>Pa.</i>					
14. Maiden Name <i>Miriam Goshorn</i>					
15. Birthplace <i>Unknown</i>					
16 (a) Informant <i>Mrs F. H. Sloan</i>					
(b) Address <i>1375 Jefferson St. Toledo, Ohio</i>					
17 (a) Burial (Burial, cremation, or removal)					
(b) Date thereof <i>Oct 9/43</i> (month) (day) (year)					
(c) Cemetery or crematory <i>London Park</i>					
Location <i>Baltimore, Md.</i>					
18 (a) Funeral director <i>Nancy H. Wether</i>					
(b) Address <i>4101 E. Edmonson Ave.</i>					
19 <i>OCT 7 1943</i> <i>Huntington Williams, M.D.</i>					
20. DATE OF DEATH <i>Oct. 7</i> 19 <i>43</i> , at <i>1:45</i> <i>A</i> M					
21. I certify that death occurred on the date above stated; that I attended deceased from <i>Aug. 30</i> 19 <i>43</i> , to <i>Oct 7</i> 19 <i>43</i> , and that I last saw him alive on <i>Oct 7</i> 19 <i>43</i> .					
Immediate cause of death <i>Hypostatic pneumonia</i>					
Due to <i>Memoria</i>					
Due to <i>Hypertension, arteriosclerosis</i>					
Other Conditions <i>C.V.D.</i>					
(Include pregnancy within 3 months of death)					
Date of operation					
Major findings of operation:					
of autopsy:					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at <i>M</i>					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?					
(e) Means of injury					
23. Signature <i>B. H. Williams</i> M. D.					
Address <i>Md. Gen Hosp.</i> Date signed <i>Oct 7, 1943</i>					

08848

440073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08848

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

G. BBS, GLOSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widower, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-12-79

8. AGE:

Years

Months

Days

If less than one day

64

63

10

24

hr.

min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

12. Name

Richard G. Glos

13. Birthplace

N.C.

14. Maiden Name

Elizabeth Glos

15. Birthplace

N.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Swann Quarter

Location

North Carolina

18 (a) Funeral director

John Q. Mitchell

(b) Address

1700 Center

19 (a) Date registered

Huntington Hills, N.C.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

N.C.

(b) County

(c) City or town

Englewood

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6

1943 at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1943 to Oct 6 1943.

and that I last saw him alive on Oct 6 1943.

Immediate cause of death Heart failure

Duration

Due to

Due to

Other Conditions

Carcinoma of bladder, urinary
Carcinoma of Prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George H. Herring

Address

J. H. H.

Date signed

10/14/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08849

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2 (a) FULL NAME

Irene Gorsuch

3 (b) If veteran, name war

No

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Dickinson Gorsuch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1875

8. AGE:

Years

Months

Days

If less than one day

68

7

22

23

hr.

min.

9. Birthplace

(Town, county, and state)

Housewife

10. Usual Occupation

11. Industry or business

Own home

FATHER

12. Name

Henry Evans

13. Birthplace

England

MOTHER

14. Maiden Name

Nester King

15. Birthplace

Maryland

16 (a) Informant Dr. Dickinson Gorsuch

(b) Address Timonium, Md.

17 (a) Burial (b) Date thereof Oct 8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

3801 Frederick Ave

18 (a) Funeral director John O. Mitchell

(b) Address 100 E. Calvert St

19 (a) Date of death Oct 7, 1943

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town

Timonium, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6, 1943, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3, 1943, to Oct 6, 1943, and that I last saw her alive on Oct 6, 1943.

Immediate cause of death Cardiorespiratory failure

Duration

Due to Hypostatic Pneumonia

3 days

Due to Shuntal pneumonia

Due to Pancreatic Hemorrhage

4 days

Due to Hypertensive Cardiovascular disease

yrs

Other Conditions

PHYSICIAN

(Include pregnancy within 3 months of death)

Date of operation Oct 3, 1943

Major findings of operation: Intraparenchymal hemorrhage.

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Murgatroyd Jr.

M. D.

Address 332 E. University Pl. Date signed 10-6-43

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08850
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 00m

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 105 Broad alley
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA SIMMS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced

Married

6 (b) Name of husband or wife Frederick Simms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1902

8. AGE: Years Months Days
41 6 2
hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name George H. Thomas

13. Birthplace Maryland

14. Maiden Name Mary?

15. Birthplace Md.

16 (a) Informant Frederick Simms

(b) Address 105 Broad alley

17 (a) Burial (b) Date thereof 10-9-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director W. Halstead

(b) Address 929 Grand Hill Ave.

19 (a) OCT 7 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1943, at 1 P. M.

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Tuberculosis of lungs

Due to

Other Conditions no

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature W. F. Wollenweber M.D.

Date signed 10-6-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08851

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location

18 (a) Funeral director

(b) Address

19 (a) (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 1943, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1943, to Oct. 5, 1943, and that I last saw him alive on Oct. 5, 1943.

Immediate cause of death

Non-specific Diarrhea

Due to

Due to

Other Conditions Malnutrition & Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Date signed M. D. 10-5-43

8852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08852
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore

(c) City Town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1886

8. AGE: Years Months Days If less than one day

57 1 13 hr. min.

9. Birthplace Delaware

(Town, county and state)

10. Usual Occupation Advertising agent

11. Industry or business Advertising

12. Name James Kirkley

13. Birthplace Delaware

14. Maiden Name Allabeda Perion

15. Birthplace Delaware

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 7 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 7 1943 (Date rec'd by registrar)

(b) Address

19 OCT 7 1943 (Date rec'd by registrar)

(b) Address

19 OCT 7 1943 (Date rec'd by registrar)

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1943 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 26 1943 to Oct 4 1943

and that I last saw him alive on Oct 4, 1943

Immediate cause of death Cachexia

Due to Carcinoma of Cecum

Due to

Other Conditions Spontaneous was

performed 9-23-43

(Include pregnancy within 3 months of death)

Date of operation 9-23-43

Major findings of operations Carcinoma

of Cecum.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas Brunson

Address Mercy Hospital

Date signed 10-2-43

M. D.

10-2-43

10-2-43

10-2-43

10-2-43

10-2-43

10-2-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a Registered No. 08853

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town

Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 203 E. North Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Archie Lewis Spradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 6 1913

8. AGE:

30

Years

5

Months

1

Days

If less than one day

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

12. Name

Columbus Spradley

13. Birthplace

Crescent, Ga.

14. Maiden Name

Augusta Holsten

15. Birthplace

Alabama

16 (a) Informant

Mrs Augusta German

(b) Address

203 E North Ave

17 (a)

Burial (b) Date thereof Oct 11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Batesburg

Location Batesburg South Carolina

18 (a) Funeral director

Reynolds & Ruch

(b) Address

5305 York Road

OCT 7 1943

H. Williams, M.D.

(Date you'd like to be buried)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1943 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1943 to Oct 7 1943, and that I last saw him alive on Oct 7 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

Due to

Hypertensive Cardio-

2 1/2 hrs.

Due to

Vascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

Signature E. W. Cheek

Address W.B. G.H.

Date signed 10/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08855
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

John Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *12 hr.*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles Joseph Ward

3 (b) If veteran, name war

10

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Louise Ward*

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Aug. 18 - 1913*

8. AGE: Years Months Days If less than one day

30 12 19 hr. min.9. Birthplace *Balto. County*

(Town, county, and state)

10. Usual Occupation *Laborer*11. Industry or business *Construction Co.*12. Name *Joseph L. Ward*13. Birthplace *Talbot Co.*14. Maiden Name *Margaret Clark*15. Birthplace *Balto. Md.*16 (a) Informant *Louise Ward*(b) Address *614 Dumbarton Ave*17 (a) *Burial* (b) Date thereof *10/9/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Cathedral*Location *Balto. Md.*18 (a) Funeral director *William Cook Inc*(b) Address *1217 St. Paul St*OCT 8 1943 (b) *Huntington Williams, M.D.*
(Date rec'd by Registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *614 Dumbarton Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-7-1943* at *10* M

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions *Multiple fractures, abrasions &**lacerations: Fractured (2)*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *10-7-43* at *2:25 A* M(b) Where did injury occur? *Fayette St. & Illinois Ave*(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *No*(d) Means of injury *Collared bet. auto. & trailer truck*23. Signature *Howard J. Luce*

M.D.

Date signed *10-7-43* Medical Examiner.

08856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G 08856
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOR

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 3110 Anchenoroly Terrace
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPH J. LIBERTO

3 (b) If veteran, name war

W

3 (c) Social Security Account
No. NONE

4. Sex

m

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Pauline Liberto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 8 1889

8. AGE: Years Months Days If less than one day
54 6 27 hr. min.

9. Birthplace

Balto Md.

10. Usual Occupation In Charge of Swimming Pool

11. Industry or business Druid Hill Park

12. Name Salvatore Liberto

13. Birthplace Italy

14. Maiden Name Posairo Baranco

15. Birthplace Italy

16 (a) Informant Pauline Liberto
(b) Address 3110 Anchenoroly Terrace17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St
Huntington Williams, M.D.
10 OCT 8 1943 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1943, at 1:30 M

21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Wollaneshere M.D.
Auth. Medical Examiner.

Date signed 10-6-43

08857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08857

Registered No.

746

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sinai Hospital 7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 weeks

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3022 Taylor Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Read

3 (b) If veteran, name war

3 (c) Social Security Account

No. 29-07-3345

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Sadie L. Read

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 22nd 1881

8. AGE:

Years

Months

Days

If less than one day

62

2

15

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

House Carpenter

11. Industry or business

Stewart, Co

FATHER

12. Name

James L. Read

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Sophia Schaum

15. Birthplace

Balto. Md.

16 (a) Informant

Sadie L. Read

(b) Address

3022 Taylor Ave

17 (a)

Burial

(b) Date thereof

10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

19 OCT 8 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/1943 at 6⁴⁵ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1943 to 10/7/1943, and that I last saw him alive on 10/6/1943.

Immediate cause of death

Septicemia

Due to

Thrombocytopenia

Due to

Alkalemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Alkalemia

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. D. Williams

Address

Lencu Corp

Date signed

10/7/43

0858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 0858
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2117 Jeanison St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Benjamin F. Horn

3 (b) If veteran, name war

W

(c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Widowed

6 (b) Name of husband or wife

Margaret E. Horn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

Mar 27 - 1861

8. AGE: Years

82

Months

6

Days

10

If less than one day

hr.

min.

9. Birthplace

Balto., Md.

10. Usual Occupation

Retired Car Inspector

11. Industry or business

Penn R.R.

12. Name

Henry B. Horn

13. Birthplace

Balto., Md.

14. Maiden Name

Margaret E. Keith

15. Birthplace

Scotland

16 (a) Informant

Margaret E. House

(b) Address

6829 Benton Heights Ave

17 (a)

Burial

(b) Date thereof

10/9/43

(c) Cemetery or crematory

Green Mount

Location

Balto., Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

OCT 8 1943

Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1217 E. Laureate St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1943 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Sept 23, 1943, to Oct 7, 1943.

and that I last saw him alive on Oct. 6, 1943.

Immediate cause of death

Coronary Thrombosis

Duration

2 wks

Due to

Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

Ventral Hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Danniel Wolfe

Address

1131 Chatham

Date signed 10-7-43

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

08859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08859

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1308 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William E. Borcharding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Cordelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 26, 1886

8. AGE:

Years

Months

Days

If less than one day

57

1

10

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Pharmacist

11. Industry or business

FATHER
MOTHER

12. Name

Henry Borcharding

13. Birthplace

Germany

14. Maiden Name

Catherine Schuman

15. Birthplace

unknown

16 (a) Informant

Cordelia Borcharding

(b) Address

1308 S. Charles St.

17 (a)

Interment

(b) Date thereof

Oct. 8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Greenmount Cem.

Location

Greenmount & Oliver St.

18 (a) Funeral director

Fred. A. Plante & Son

(b) Address

1216 S. Charles St.

19 (a)

OCT 8 1943

(b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct - 5 1943, at 7⁵⁰ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1942 to Oct 5 1943, and that I last saw him alive on Oct 4 1943

Immediate cause of death

Coronary

Duration

5 mo

Due to

Chronic myocarditis
arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul J. Trautman

Address

LYV L See H

Date signed

10/7/43

G 08860

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08860
Registered No.

1. PLACE OF DEATH: 4913 Lenmore Ave
(a) Baltimore City, Maryland 13 Lenmore Ave
(b) Street address 4913 Lenmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4913 Lenmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Shabsis

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-42

8. AGE: Years Months Days If less than one day
4 3 23 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Hymon Shabsis

13. Birthplace Russia

14. Maiden Name Sally Mark.

15. Birthplace Poland.

16 (a) Informant Hymon Shabsis

(b) Address 4913 Lenmore Ave

17 (a) Burial (b) Date thereof 10-8-42
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Waverly Circle
Location Baltimore, Md.

18 (a) Funeral director Jase Newman

(b) Address 1439 E. Balto. St

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 8 1943 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1943 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9-1943 to 10-7-1943 and that I last saw him alive on 10-7-19

Immediate cause of death

Due to Septicaemia.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. H. Finckelstein

Address 11-E Chase St. Date signed

Duration

24 hrs.

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08861
50 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Williams & Caton Ave.*
(c) Hospital or institution: *St. Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *15-8*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County
(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3407 Duval Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Veda Coates

(*SADIE VEEDA COATES*)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *George G. Coates*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1894*
8. AGE: Years *49* Months Days If less than one day hr. min.

9. Birthplace *Russell*
(Town, county, and state)

10. Usual Occupation *House Work*

11. Industry or business

12. Name *Maude Wolfe*

13. Birthplace *Russell*

14. Maiden Name *Anna Dressner*

15. Birthplace *Russell*

16 (a) Informant *George G. Coates*
(b) Address

17 (a) *Burial* (b) Date thereof *10-8-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Woodlawn*
Location *Woodlawn Md*

18 (a) Funeral director *Paul Lewis*
OCT 8 1943

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/5/1943 3 9 M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 16* 19*43* to *10-7* 19*43*, and that I last saw her alive on *10-7* 19*43*.

Immediate cause of death *Carcinoma of Breast & Pulmonary metastasis*

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *John J. Mues*
Address *St. Agnes Hosp* Date signed *10/7/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08862
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5 Color of skin

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by reg.)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at 10/5 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 10/4 1943 to 10/5 1943
and that I last saw him alive on 10/4/43

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date

NOT 8

G 08863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08863

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1639 Westwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days): Life

3 (a) FULL NAME Harry Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

C.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 28 - 1881

8. AGE:

Years

Months

Days

If less than one day

62

2

7

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Stereos

11. Industry or business

FATHER
MOTHER

12. Name

Peter Smith

13. Birthplace

Md

14. Maiden Name

Lizzie Allaire

15. Birthplace

Md

16 (a) Informant

Jackie Spade

(b) Address

1639 Westwood Ave

17 (a)

Burial

(b) Date thereof

8-9-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

Same N. Chase St

18 (a) Funeral director

B. N. Hatcher

(b) Address

638 N. G. Street

19 (a)

OCT 8 1943

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(d) Street No.

1639 Westwood

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-5

1943 at 9:46 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Aug 2 1943 to 10/5 1943, and that I last saw him alive on 10/5 1943.

Immediate cause of death

Cardio-Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

B. N. Hatcher

Address

1775 P. Ave

Date signed

10/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AD-83618 08864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08864

Registered No.

93d

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **4940 Eastern Ave.**
 (c) Hospital or institution: **Baltimore City Hospitals**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **1 mo. 5 days**(e) Length of stay in Baltimore (yrs., mos., or days) **38 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County _____
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **6028 Old Harford Road**
 (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

Lester Waller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White6 (a) Single, married, widowed, or divorced. **Widower**

6 (b) Name of husband or wife

Ora (Dead)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 15- 1875

8. AGE: Years

68

Months

4

Days

22

If less than one day

hr.

min.

9. Birthplace **Md.**

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER12. Name **James Waller**

13. Birthplace

?

14. Maiden Name

Louise Jones

15. Birthplace

Md.16 (a) Informant **Baltimore City Hospitals**

(b) Address

Records17 (a) ~~Funeral home~~ (b) Date thereof**Oct. 19, 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Vernon Cemetery

Location

Principes and Rd.

18 (a) Funeral director

Charles J. General

(b) Address

Principes and Rd.

19 (a)

(b) Date received by registrar

Oct. 8 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/7**1943. 8:00 A**

21. I certify that death occurred on the date above stated, that I attended deceased from **9/4** 1943, to **10/7** 1943, and that I last saw him alive on **10/7** 1943.

Immediate cause of death

Arteriosclerosis

Due to

General atherosclerosis

Due to

A.S.C. disease

Duration

6 d**18 mo.**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Sargman

Address

BCH

Date signed

M.D.

9/7

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08865

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1046 N. Milton Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Joseph Anderson

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1887

8. AGE:

Years

Months

Days

If less than one day

56

0

5

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

Unemployed

LABORER

11. Industry or business

FATHER

12. Name John Anderson

13. Birthplace Md.

MOTHER

14. Maiden Name Anna McCauley

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(RECORDS)

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 9/4 3

(month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.

(b) Address 403 SCHOLFE ST.

19 (a) OCT 8 1943

(b) Date of registration

(c) Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6/43 19 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9:25 1943 to 10-6 1943, and that I last saw him alive on 10-6 1943.

Immediate cause of death

Pulmonary Thrombosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Paul Hall

Address

Rev

Date signed 10/7/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08867

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

26-10-10
10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Emma M. Cann

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife

James M. Cann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 10-1893

8. AGE:

Years

Months

Days

If less than one day

50

1

26

hr.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual Occupation

At Home

11. Industry or business

12. Name

Adolph Liersemann

13. Birthplace

Germany

14. Maiden Name

Alvina Altenberg

15. Birthplace

Germany

16 (a) Informant

Miss Louise Liersemann

(b) Address

260 S. East Ave

17 (a)

Burial

(b) Date thereof

Oct 11-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mount Pleasant Memorial Park

Location

Rural

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2104 Williams St.

19

OCT 8

1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

260 S. East Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 6 1943, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended

deceased from 8/26 1943, to 10/6 1943,

and that I last saw him alive on 10/6 1943.

Immediate cause of death

Sepsis

Due to

Tubo-Peritonitis

Due to

Pyelo-nephritis

Other Conditions

Infected decubitus ulcer

Malaria - inoperable

Cellulitis (left thigh)

Date of operation

Major findings of operations:

of autopsy

Pneumonia (left)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. Olsen

Address

University Hosp

Date signed

9/6/43

08868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08868

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1028 Mc Donough St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

C.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 25, 1897

8. AGE:

Years

Months

Days

If less than one day

45

9

10

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

John Eaton

13. Birthplace

N. C.

14. Maiden Name

Mary Eaton

15. Birthplace

N. C.

16 (a) Informant

James Claiborne

(b) Address

1028 Mc Donough St

17 (a) Burial

(b) Date thereof 10/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

MT. Calvary

Location

A. A. County, Md.

18 (a) Funeral director

Joseph B. Cook

(b) Address

1364 N. Central St.

19 (a)

(Date rec'd by Registrar)

OCT 8 1943

Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 5 1943, 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1943 to Oct. 5 1943 and that I last saw him alive on Oct. 5 1943.

Immediate cause of death

Acute myocardial infarction

Due to

Pulmonary tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Wm. L. Cheney

Address

1920 E. Chase

Date signed

10. 7. 43

Duration

1 day

20 days

3 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08869

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1519 W. Franklin

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baeto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1519 W. Franklin St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female Colored Widow

6 (b) Name of husband or wife John W. Pinder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4, 1872

8. AGE: Years 71 Months 9 Days 2
If less than one day hr. min.

9. Birthplace Baeto
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Peter Francis

13. Birthplace Md

14. Maiden Name Louise Martin

15. Birthplace Md

16 (a) Informant Edna Travis Lynn

(b) Address 1519 W. Franklin St

17 (a) Burial (b) Date thereof Oct 10-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A. Hayes

(b) Address 142 W. 1st St

19 OCT 8 1943
Date signed by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1943 at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1943 to Oct 6 1943, and that I last saw him alive on Oct 6 1943.

Immediate cause of death

Due to Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Charles T. Waller

Address 861 N. 1st St Date signed 10/8/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08870

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
Lake Drive Apts.
(b) Street address 911 Lake Drive
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Drive Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

3 (a) FULL NAME

MAMIE MINTZ

3 (b) If veteran, name war
---3 (c) Social Security Account
No. -----

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced
Married

6 (b) Name of husband or wife Julius Mintz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1875.

8. AGE: Years 67

Months 9

Days 24

If less than one day
hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Abraham Weinberg,

13. Birthplace Budapest.

14. Maiden Name Regina Weinberg,

15. Birthplace Budapest.

16 (a) Informant Mr. Daniel Weinberg,

(b) Address Lake Drive Apts.

17 (a) Burial (b) Date thereof 10/8/43.
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director

(b) Address 2 Eutan place

(c) Date rec'd by registrar 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6th, 1943, 2:10 P M

21. I certify that death occurred on the date above stated, that I attend-
ed deceased from June 1943, to Oct 6, 1943.
and that I last saw her alive on Oct 6, 1943

Immediate cause of death

Coronary Thrombosis
Cardiac Insufficiency
Due to General Arteriosclerosis
Hypertension
Cardiac Hypertrophy

Duration

2 weeks

2-7 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address 2107 Park Ave.

Date signed 10/11/43

PHYSICIAN

Underline the
cause to which
death should be
charged stat-
istically.

G 08871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08871
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1943 to Oct 7 1943, and that I last saw her alive on Oct 7 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Approved:

Robert Lee Graham M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 8 1943

Approved:

Robert Lee Graham M.D.

G 08872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08872

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *505 Claggett St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *17-3*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Sarah Sallie Bishop

3 (b) If veteran, name war

3 (c) Social Security Account
No. *None*

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

George Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 2, 1852

8. AGE:

Years

Months

Days

If less than one day

*91**6**4*

hr.

min.

9. Birthplace

Salisbury Md.

10. Usual Occupation

Old Age Pension

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

Katie Porter

15. Birthplace

Salisbury Md.

16 (a) Informant

Clarence Bishop

(b) Address

*519 Claggett St*17 (a) *Burial*

(b) Date thereof

Oct 8, 1943

(c) Cemetery or crematory

St John Am.

Location

18 (a) Funeral director

Mrs Katie R. Williams

(b) Address

322 N. Schieler St

19 (a)

Date of registration

Oct 8 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

505 Claggett St

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct 6 1943 at 1:15 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 1 1943 to Oct 6 1943* and that I last saw him alive on *Oct 6 1943*

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

Not applicable

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Chas. H. Marshall

M. D.

Address

*411 N. State St*Date signed *10/8/43*

OCT 8 1943

VS 1

G 08873

BALTIMORE CITY HEALTH DEPARTMENT

G 08873

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (h) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Date read by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1943 at 1:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1943 to Oct 6 1943, and that I last saw him alive on Sept 28 1943.

Immediate cause of death

Myocardial infarction
Calcular heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08874
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Pier # 11 Lower Canton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

George L. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 23-1921

8. AGE:

Years 22

Months 7

Days 14

If less than one day

hr. min.

9. Birthplace

Hamilton Co. Ohio

(Town, county, and state)

10. Usual Occupation

U. S. Coast Guard

11. Industry or business

Machinist Mate 2nd class

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden Name

Pearl

15. Birthplace

Ohio

16 (a) Informant

U. S. Coast Guard

(b) Address

Capt of Port. office

17 (a)

Burial

(b) Date thereof

Oct 8-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Columbus Ohio

18 (a) Funeral director

Roth & D. M. Walter

(b) Address

Pier & Stucker Sts

19 (a)

Date registered

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1943, at 5 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

10/7/43 at 3:45 P. M.

(b) Where did injury occur?

Pier # 11 Lower Canton

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury

Fall off boat

23. Signature

Robert L. Fritham

M.D.

Date signed

Oct. 7

1943

G 08875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08875

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1316 E. Monument St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Spf

3 (a) FULL NAME

Sarah V. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Joseph Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/60

8. AGE: Years Months Days If less than one day

83 84 5 29 hr. min.9. Birthplace Balto, Co. Ind.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name John Wilson13. Birthplace Balto Co. Ind.14. Maiden Name Ellen E. Dodd15. Birthplace Balto Co. Ind.16 (a) Informant Elena Butler(b) Address 1316 E. Monument St17 (a) Burial (b) Date thereof Oct 8-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Int. Calvary CemeteryLocation Int. Calvary Cemetery18 (a) Funeral director Robert E. Williams(b) OCT 8 194319 (a) 1943 (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1316 E Monument St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1943 11:45 M21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Oct 4 1943 and that I last saw her alive on Oct 4 1943.Immediate cause of death Chronic Nephritis
(uremia)Duration
Sept 15 1943

Due to

Due to

Other Conditions Metastatic Inefficiencyand Anterior Sclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ralph J. YoungAddress 1429 E Monument Date signed 10/7/43

08876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08876

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2902 Overland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JULIET WRIGHT

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or

divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Oct. 20-1875

8. AGE:

Years 68

Months 5

Days 16

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name

John Wright

13. Birthplace

Baltimore

14. Maiden Name

Juliet Piersol

15. Birthplace

Columbia, Pa.

16 (a) Informant

Mrs. Charles Hill

(b) Address

2902 Overland Ave.

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

10/8/43

(month) (day) (year)

(c) Cemetery or crematory

Greenmount Cem.

Location

Balto., Md.

16 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 OCT 8 1943

Certified by

W. J. Tickner

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2902 Overland Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1943, 7:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4-1943 to 10-6-1943, and that I last saw her alive on 10-5-1943.

Immediate cause of death

Chronic myocarditis

Duration

Due to

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 2801 Hartford Rd Date signed 10-7-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 08877
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3213 Westwood Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 3213 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES O. WRIGHT
3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4 Sex Male 5 Color or race White 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1877
8. AGE: Years 66 Months 1 Days 17 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Musician
11. Industry or business Asst. Mgr.

12. Name John T. Wright
13. Birthplace Baltimore, Md.
14. Maiden Name Anna S. Bati
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna G. Wright
(b) Address 3213 Westwood Ave

17 (a) Burial (b) Date thereof 10/8/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 8 1943 Huntington Hill, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1943 at 10 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1940 to Oct 6/43 and that I last saw him alive on Oct 5/43

Due to Chronic myocardial infarction
Due to Acute dilatation
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Manner of injury
23. Signature Dr. C. A. Stewart M.D.
Address 1929 W. M. St.
Date signed 10/7/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

08878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08878
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rebecca Talbot

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4 Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1863

8. AGE: Years 80 Months 9 Days 3 hr. min.

9. Birthplace Balb. Co. Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Stanley Talbot

13. Birthplace Md.

14. Maiden Name Elizabeth A. Green

15. Birthplace Maryland

16 (a) Informant Florence Robinson

(b) Address 2320 Daniel Hill Ave.

17 (a) Burial (b) Date thereof Oct. 8, 1943

(c) Cemetery or crematory (d) Location

Fullerford, Md.

18 (a) Funeral director Mrs. Lee M. Stollard

(b) Address 1531 Daniel Hill Ave.

Date of death Oct 8 1943

Signature of physician Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1124 Division St.

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1943 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1943 to Oct 5 1943 and that I last saw her alive on Oct 5 1943

Immediate cause of death

Cerebral Hemorrhage

Duration 10 days

Due to Hypertension and Arteriosclerosis

Due to

Other Conditions Left Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature J. H. Bayfield

Address Provident Hospital Date signed 10-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

OCT 8

VS 154

G 08879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08879

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3210 Montebello Terrace

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3210 Montebello Terrace

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Katherine M. Hoeflich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

female

white

married

6 (b) Name of husband or wife Adolph F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1873

8. AGE: Years Months Days If less than one day

70

4

21

20

hr. min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER
MOTHER

12. Name Christain Schwemm

13. Birthplace Germany

14. Maiden Name Mary Gardner

15. Birthplace Germany

16 (a) Informant Adolph F. Hoeflich

(b) Address 3210 Montebello Terrace

17 (a) Burial (b) Date thereof 10/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cen.

Location Baltimore, Md.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

8 (a) 1948 Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1943, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1940 to Oct 6 1943.

and that I last saw him alive on Oct 5 1943.

Immediate cause of death

Chronic Myocarditis

Duration

5 years

Due to

Due to

Other Condition

Renal Arterio-sclerosis 6 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature R. F. Hardy M.D.

Address 5106 Harbor Rd. Date signed 10-8-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08880

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 08880
Registered No. 1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 S. Lakewood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 522 S. Lakewood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Ignatius Krasniewski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Ludwika Smolinski
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Feb 1 1880
8. AGE: Years 68 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

12. Name Frank Krasniewski
13. Birthplace Poland
14. Maiden Name Jozefa Goscinska
15. Birthplace Poland

16 (a) Informant Mrs. Ludwika Krasniewski
(b) Address 522 S. Lakewood ave

17 (a) Burial (b) Date thereof Oct 9 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cms
Location Baltimore County

18 (a) Funeral director John M. Welch
(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1943 at 4:55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 5 1943, and that I last saw him alive on Oct 5 1943.

Immediate cause of death M. Malignant Tuberculosis
Due to Mediastinal Tbc.
Due to
Other Conditions

Duration
?
?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature Lawrence J. Shimanaka
Address 3711 Falls Rd Date signed 10-7-43

Shimanaka

08881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08881
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1437 N. Charles St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Arthur Oehm

3 (b) If veteran, name war

3 (c) Social Security Account
No. --

4. Sex

male

5. Color or race

white6 (a) Single, married, widowed, or
divorced.single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 1, 1869

8. AGE:

Years

Months

Days

If less than one day

7436

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Prof. of music

11. Industry or business

FATHER
MOTHER

12. Name

Frederick Wm. Oehm

13. Birthplace

Germany

14. Maiden Name

Marie S. Biemiller

15. Birthplace

Germany

16 (a) Informant

Arthur Oehm

(b) Address

509 Quintana Place, Wash.

17 (a) Burial

(Date thereof)

10/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cem.Location Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

OCT 8 1943Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1943, at 3:50 P.M.21. I certify that I took charge of the remains described above, held an
Inspection & Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were,IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert L. Graham

M.D.

Date signed October 7, 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G

08882

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *802 Ostend St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *25 yrs*

3 (a) FULL NAME

Bessie Carter Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *12-15-1902*

8. AGE:

Years

Months

Days

If less than one day

40

9

20

hr.

min.

9. Birthplace

Petersburg Va

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Charles Anderson

13. Birthplace

Va

MOTHER

14. Maiden Name

Mattie ?

15. Birthplace

Va

16 (a) Informant

James Coleman

(b) Address

802 Ostend St

17 (a)

Burial

(b) Date thereof *10-9-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

W. Auburn Cem

Location

Baltimore Md

18 (a) Funeral director

William A Jackson

(b) Address

916 Penna ave

19 (a)

(Date rec'd by registrar)

(b)

William A Jackson

(Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. *802 Ostend St*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/5

19 *43* at *1 P.* M

21. I certify that death occurred on the date above stated; that I attended deceased from *9/24* 19 *43* to *10/5* 19 *43*, and that I last saw him alive on *10/5* 19 *43*

Immediate cause of death

Pneumonia

Due to

Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm A Jackson

Address

601 N. Calhoun

Date signed

10/7/43

OCT 8 1943

G 08833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08883

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For Dr. W. H. Kelly - by Thomas J. Madden, M.D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G. 08884
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

WILLIAM THOMAS HARRISON

3 (b) If veteran, name war

3 (c) Social Security Account

No. 228-10-5621

4. Sex
Male

5. Color or race
Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1908

8. AGE: Years 35 Months Days If less than one day
hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Salon

12. Name William J. Harris

13. Birthplace Virginia

14. Maiden Name Emma Easter

15. Birthplace Virginia

16 (a) Informant William Thomas Harrison

(b) Address 598 W. Biddle St.

17 (a) Burial (b) Date thereof 10 10 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Family
Location Emporia, Va.

18 (a) Funeral director H. H. Harris

(b) Address 9 S. Bond St. Baltimore

19 OCT 8 1943

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1943 at 11:10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Bullet wound of chest.

Due to

Other Conditions

(Include pregnancy within 1 month of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 1, 1943 10:45 P. M.

(b) Where did injury occur? Poplar & Pierce St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work?

(d) Means of injury Bullet wound of chest. Rorsch

23. Signature H. A. Wollman M.D.

Date signed 10-2-43

Medical Examiner.

Normal Cause of death

08885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

08885

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19

OCT 8 1943

(b) Huntington Halliday, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/7 1943 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1943 to 10/7 1943

and that I last saw her alive on 10/7 1943

Immediate cause of death

Sacro-Intestinal
Hemorrhage

Due to

Idiopathic Perforation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/1/43

Major findings of operation:

Adenocarcinoma of Uterus

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

10/7/43

Duration

24 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08886
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2323 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race white
6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1862

8. AGE: Years 81 Months 1 Days 16
If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Home duties

11. Industry or business

12. Name James Smith

13. Birthplace Md.

14. Maiden Name Emily Vernay

15. Birthplace Md.

16 (a) Informant Mr. Winfield Scott Ditch
(b) Address Riderwood, Md.

17 (a) Burial (b) Date thereof 10/9/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director John A. Mitchell
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd) (year) Registrar

OCT 8 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 1943
and that I last saw him alive on Sept. 30, 1943

Immediate cause of death

Cerebral aneurysm
Due to Chronic heart disease 8 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature Bowman J. Hord, M.D.

Address 317 Broxton Road Date signed

Duration 20 min

8 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08887
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 6 Midvale Road
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)
 (e) Length of stay in Baltimore (yrs., mo., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore,
 (If outside city or town limits, write RURAL and give town)
 6 Midvale Road
 (d) Street No. (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Susan E. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife John Lee Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1853

8. AGE: Years 90 Months 4 Days 25 If less than one day
 hr. min.

9. Birthplace Ohio
 (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Peter Kiester
 13. Birthplace Pa.

14. Maiden Name Mary Bashore
 15. Birthplace Pa.

16 (a) Informant Grace W. Renneburg
 (b) Address 6 Midvale Road

17 (a) Burial (b) Date thereof 10/9/43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John C. Mitchell Home Inc.
 (b) Address 1900 Eutaw Place

19 (a) OCT 8 1943
 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 19 43, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1943, to Oct 6, 1943, and that I last saw him alive on Oct 6, 1943.

Immediate cause of death

Arterio-sclerotic
 Heart Disease
 Due to Myocardial Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature H. Gibson Porter
 Address 4822 Roland Ave Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08888

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Wilkes & Caton*
 (c) Hospital or institution: *St. Agnes Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *25*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Harford*
 (c) City or town *Chesapeake*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years *54* Months Days If less than one day
 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Mrs. Flippo*13. Birthplace *Va.*14. Maiden Name *Minnie Markham*15. Birthplace *Va.*16 (a) Informant *Peter Henner*16 (b) Address *Aberdeen Md.*17 (a) *Burial* (b) Date thereof *Oct. 8, 1943*
 (Burial, cremation, or removal) (month) (day) (year)17 (c) Cemetery or crematory *Buchanan*
 Location *Buchanan Va.*18 (a) Funeral director *Martin Taylor & Sons*18 (b) Address *1827 N. North Ave.*19 (a) *OCT 8 1943* *Huntington Williams, M.D.*
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-8* 19*43* at *4:05* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *9/12* 19*43* to *10-8* 19*43*, and that I last saw her alive on *10-8* 19*43*.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Alfred J. Garrison*Address *St. Agnes Hosp* Date signed *10/8/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08889

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08889
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Balto.

(c) City or town Essex

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1303 Eastern Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

William Hartung

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan-17-1876

8. AGE:

Years

Months

Days

If less than one day

67

8

20

hr.

min.

9. Birthplace

Pitts. Penna.

(Town, county, and state)

10. Usual Occupation

Millwright

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date registered

1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1943, at 7:25 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mulderis M.D.

Date signed 10-7-43 Medical Examiner.

G 08890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08890

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Sparrows Point

(If outside city or town limits, write RURAL and give town)

(d) Street No. 7210

Bayfield Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Ligler, Baby Girl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1943

8. AGE:

Years

Months

Days

If less than one day

0

0

10

hr.

min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation

New Born

11. Industry or business

FATHER
MOTHER

12. Name

Ralph Ligler

13. Birthplace

Ohio

14. Maiden Name

Margaret Jordan

15. Birthplace

Baltimore Md

16 (a) Informant Mrs Margaret Ligler

(b) Address 7210 Bayfield Road

17 (a) Burial, cremation, or removal

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location Sacred Heart

18 (a) Funeral director

John A. M. Man

(b) Address

3000 E. Balto. Rd.

19 (a)

(Date rec'd by registrar)

H. H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 7 1943 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1943 to Oct 7 1943, and that I last saw her alive on Oct 7 1943.

Immediate cause of death

Asphyxia of the Esophagus
(at junction of the upper & middle third)
Due to

Duration

Birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John M. Cullen Jr

M. D.

Address

Church Home & Hosp

Date signed 10-8-43

OCT 8 1943

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08891
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home + Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 310 Pen St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas T. Lamasan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1874

8. AGE: Years 67 Months 7 Days 18 If less than one day hr. min.

9. Birthplace Norway
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Hans T. Lamasan

13. Birthplace Norway

14. Maiden Name Louise Peterson

15. Birthplace Norway

16 (a) Informant Mrs. Anna Gaidis

(b) Address 401 S. Lombard Ave.

17 (a) Burial, cremation, or removal (b) Date thereof Oct 9-43
(month) (day) (year)

(c) Cemetery or crematory location
Woodland Memorial
Taylor Avenue

18 (a) Funeral director John C. Preblichman Jr.

(b) Address 423 S. Park St.

19 (a) OCT 8 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1943, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1943, to Oct 6 1943, and that I last saw him alive on Oct 6 1943.

Immediate cause of death

Pulmonary edema

Due to Bacterial pneumonia?

2 days

Due to Appendicitis acute with abscess

6 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-3-43

Major findings of operations:

Ruptured appendix with abscess of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabelle Lamasan

M. D.

Address Church Home + Hospital Date signed Oct 6-43

G 08892

BALTIMORE CITY HEALTH DEPARTMENT

G 08892

Registered No.

CERTIFICATE OF DEATH

131B

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley Street

(c) Hospital or institution:

Little Sisters of the Poor(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Dennis O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1865

8. AGE: Years

78

Months

Days

If less than one day

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name

Dennis

13. Birthplace

Ireland

MOTHER

14. Maiden Name

Elizabeth Laughlin

15. Birthplace

Ireland

16 (a) Informant

Little Sisters of the Poor

(b) Address

1200 Valley Street, Balto. Md.

17 (a)

Burial

(b) Date thereof

Oct. 9, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore

18 (a) Funeral director

Rita Wredefield

(b) Address

914 Pennsylvania Ave.

Date signed

10/10/43

(Signature)

William H. H.

MEDICAL CERTIFICATION

11:30 p.m.

20. DATE OF DEATH

Oct. 71943, atM21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 - 1943, to Oct 7 - 1943.and that I last saw him alive on Oct 7 - 1943.

Immediate cause of death

Edema Lungs -

Due to

Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. G. Hall

M. D.

Address

7631 E. North Ave.

Date signed

Oct 8 - 43

Dr. Henry B. Hovick
29 W. North av

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08893

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2704 Presbury st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Presbury st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John A. Ealbeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

Mollie Constantine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 5 1881

8. AGE: Years

62

Months

7

Days

2

If less than one day

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Delivery Man

11. Industry or business

H. J. Heing Co

FATHER

12. Name

John A. Ealbeck

13. Birthplace

Balto Md

MOTHER

14. Maiden Name

Elizabeth Paul

15. Birthplace

Balto Md

16 (a) Informant

Wife, Mollie Ealbeck

(b) Address

2704 Presbury st

17 (a) Burial

(b) Date thereof Oct 9 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

all Saints

Location

Reisterstown Md

18 (a) Funeral director

Frank V. Lepitone

(b) Address

2818 E. Baltimore st

19 (a)

(b)

(Date registered)

William H. Hovick

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/7/43 5-20 P M

21. I certify that death occurred on the date above stated that I attended deceased from

and that I last saw him live on 10/7/43

Immediate cause of death

Heart Pneumonia

Duration

13 days

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Hovick

Address

Date signed 10/7/43

OCT 8, 1943

Write age in especially important. Physician: please write the causes of death clearly and legibly.

G 08894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

08894

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

33rd St. A.

(c) Hospital or institution

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Balto.

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4109 Guilford Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Estelle Clifton Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Philemon H. Griffith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 23, 1871

8. AGE:

Years

Months

Days

If less than one day

72

15

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Registrar of Nurses

11. Industry or business

Graduate Nurse.

12. Name

Charles A. Glocker.

13. Birthplace

Baltimore, Md.

14. Maiden Name

Julia A. Paine

15. Birthplace

Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Flanigan

(b) Address Edgewood Arsenal, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 11, 1943

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore, Md.

18 (a) Funeral director

Wm. L. Amorson

(b) Address

4510 Liberty Heights Ave.

19 (a) Date of death

Oct 8 1943

Therestington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1943, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 7, 1943, to Oct. 8, 1943, and that I last saw her alive on Oct. 8, 1943.

Immediate cause of death

Pulmonary edema

Due to

Myocardial Failure

Due to

Hypertensive heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Geo. W. Montgomery Jr.

M. D.

Address 332 E. University Heights signed 10/8/43

Physician

2-3 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08896
Registered No.

84123

ya

13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Avenue**
(c) Hospital or institution: **BALTIMORE CITY HOSPITALS**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **5 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **life**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md.** (b) County
(c) City or town **Balto.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2222 Annapolis Rd.-Westport**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME **Albert MacKubin**

3 (b) If veteran, name war
3 (c) Social Security Account No. **216-07-6386**

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Separated**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 24, 1884**

8. AGE: Years **59** Months **11** Days **11** If less than one day hr. min.

9. Birthplace **Maryland (Balto.)**
(City, county, and state)

10. Usual Occupation **Milkwright**

11. Industry or business **Gas Appliance Co**

12. Name **Clarence H. MacKubin**

13. Birthplace **Md. (Balto.)**

14. Maiden Name **Katherine Lloyd**

15. Birthplace **Md. (Balto.)**

16 (a) Informant **BALTIMORE CITY HOSPITALS**

(b) Address **(RECORDS)**

17 (a) **Burial** (b) Date thereof **10/5/43**
(Burial, cremation, or other) (month) (day) (year)

(c) Cemetery or crematory **London Park**
Location **Balto. Md.**

18 (a) Funeral director **William Cook Inc**

(b) Address **147 St. Paul St.**

19 (a) **OCT 8 1943**
(Date rec'd by registrar) **Huntington Williams**

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH **10/5 1943 at 8:15 H.M.**
21. I certify that death occurred on the date above stated; that I attended deceased from **1912** 19 **13** to **10/5 1943**, and that I last saw him alive on **10/6 1943**.

Immediate cause of death
Pulmonary TBC

Due to

Due to

Other Conditions **bronchitis**

(Include pregnancy within 5 months of death)

Date of operation
Major findings of operation:

of autopsy: **no post**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **E. L. Seigman**

Address **B. C. D.** Date signed **10/7**

Duration
20 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

08897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08897
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: *Provident Hospital 14-2*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 mo.*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *MD* (b) County *Anne Arundel*
(c) City or town *Parole, Md.* (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Joseph Hawkins*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *Negro* 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3-22-43*
8. AGE: Years Months Days If less than one day
8 *16* hr. min.

9. Birthplace *Parole, Md.* (Town, county, and state)
10. Usual Occupation *Driver*
11. Industry or business

FATHER 12. Name *Raymond Hawkins*
13. Birthplace *Eastport Md.*

MOTHER 14. Maiden Name *Conia Smith*
15. Birthplace *Parole, Md.*

16 (a) Informant *Conia Smith*
(b) Address *Parole, Md.*

17 (a) *Burial* (b) Date thereof *Oct. 10 1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Brewer Hill*
Location *Annapolis*

18 (a) Funeral director *J. B. Johnson*
(b) Address *1333 N. ...*

(a) *10-9-43* (b) *10-9-43*
Date registered Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 8 1943 at 2:30 P.M.*
21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 7 1943 to Oct 8 1943*, and that I last saw him alive on *Oct 8 1943*.

Immediate cause of death
Pneumonia
Due to *Primary Tuberculosis*
Due to
Other Conditions *Myocardial Failure*
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *W. H. Bayfield* M. D.
Address *Provident Hospital* Date signed *10-9-43*

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

088898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 088898
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Girl Gerst

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-30-43

8. AGE:

Years

Months

Days

If less than one day

hr. 20 min.

9. Birthplace Union Memorial Hosp. Baltimore
(Town, county, and state) M.D.

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Peter John Gerst

13. Birthplace Perry Hall, Maryland

14. Maiden Name Mildred Clara Ray

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs P.J. Gerst

(b) Address 1911 E. Preston St. City.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

Oct 9 1943
(Date received by registrar)

Thurston Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 19 43, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h&v alive on 9-30 19 43.

Immediate cause of death

Immaturity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James H. McLeod
Address Union Memorial Hospital Date signed 9-30-43
M.D.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

08899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08899
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2227 Brunt Street

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

3 (a) FULL NAME

Paul

Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/9/42

8. AGE:

Years

Months

Days

If less than one day

0

1

11

28

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

FATHER
MOTHER

12. Name

Oliver Conway

13. Birthplace

Maryland

14. Maiden Name

Ethel Dunlap

15. Birthplace

Maryland

16 (a) Informant

Ethel Conway

(b) Address

2227 Brunt St.

17 (a)

Burial

(b) Date thereof

Oct 11-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Peter's Cemetery

Location

Va Brooks

18 (a) Funeral director

(b) Address

1463 P. Carey St.

OCT 9 1943
(Date rec'd by registrar)

(c) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 7, 1943 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Graham M.D.

Date signed

Oct 8 1943

G 08900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08900
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address William W. Lester Jr.
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
(c) City or town Baltimore
(d) Street No. 110 Melvin St. Baltimore
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Upshur Jr Scott

3 (b) If veteran, name war

3 (c) Social Security Account
No. 214-14-9181

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Lance D. Scott6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

July 22 - 1875

8. AGE:

Years

Months

Days

If less than one day

68216

hr.

min.

9. Birthplace

Macon, Ga
(Town, county, and state)

10. Usual Occupation

Printer

11. Industry or business

House PainterFATHER
MOTHER

12. Name

William Scott

13. Birthplace

GA

14. Maiden Name

Willa Smith

15. Birthplace

GA

16 (a) Informant

Lance D. Scott

(b) Address

110 Melvin St Baltimore

17 (a)

Burial

(b) Date thereof

10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or repository

L Lane

Location

Woodlawn, Md

18 (a) Funeral director

F. J. Wofford, Inc

(b) Address

300 E. Baltimore St Baltimore

19 (a)

OCT 9 1943

(Date by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1943, at 2:10 P.21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Subarachnoid
hemorrhage, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury October 7, 1943 7:25 A.M.(b) Where did injury occur? Englewood Gas Station(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No(d) Means of injury Struck by auto

23. Signature

Robert E. Butler M.D.

Date signed

Oct. 7 1943

G 08901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08901

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 33rd + Calvert Sts.
- (c) Hospital or institution: Union Memorial Hosp.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 3
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 4101 N. Charles St.
(If rural, give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

George W. H. Pierson

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 216-14-8916

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Margaret Pierson

6 (c) If alive, give age

68 years

7. Birth date of deceased (mo., day, yr.)

Apr-1-1876

8. AGE:

67

Years

6

Months

6

Days

6

If less than one day

hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Builder

11. Industry or business

FATHER

12. Name Mr Henry Pierson13. Birthplace England

MOTHER

14. Maiden Name Catherine Fulling15. Birthplace Baltimore

16 (a) Informant

Medical Chart

(b) Address

17 (a)

Burial

(b) Date thereof

Oct 11, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

3801 Frederick Ave

18 (a) Funeral director

Mr. Mrs. John W. Trefel. Son

(b) Address

8914 E. Parrell St.

19 (a)

OCT 9 1943

(b) Registrar

Hamington Williams, Jr.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1943 at 7:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to Oct 7 1943, and that I last saw him alive on Oct 7 1943.

Immediate cause of death

Cardio-respiratory failureDue to Terminal PneumoniaDue to Congestive Heart FailureAnteriorly located heart diseaseOther Conditions Congestive Heart Failure

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____ (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature

John A. Trefel

Address

Union Memorial Hosp.Date signed 10-7-43

When filling out this form, every item of information should be carefully supplied. Every item of information is especially important. Physicians: please write the causes of death clearly and legibly.

G 08902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08902
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *501 N. Calmar St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

*Colored*6 (a) Single, married, widowed, or
divorced.*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 21, 1908*

8. AGE: Years Months Days If less than one day

*35**-**16**hr.**min.*9. Birthplace *South Carolina*
(Town, county, and state)10. Usual Occupation *Tailor*

11. Industry or business

12. Name *David McKenney*13. Birthplace *S. C.*14. Maiden Name *Sadie McKenney*15. Birthplace *S. C.*16 (a) Informant *Mr. Thomas McKenney*(b) Address *Room 622 N. Carrollton Ave.*17 (a) *Burial* (b) Date thereof *10-10-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location *Rock Hill, S.C.*18 (a) Funeral director *Mrs. Frances A. Hemsley*(b) Address *578 W. Biddle St.*

19 (a) (b)

*OCT 9 1943**McKinney*
MEDICAL CERTIFICATION20. DATE OF DEATH *October 7, 1943, at P. M.*

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH *Generalized**peritonitis*Due to *Bullet wound of abdomen*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *9/24/43* *9:30 P.*(b) Where did injury occur? *1105 Edmondson Ave.*

(c) Did injury occur at home, on farm, industrial place, in public

place? *Friend's home* While at work? *No*(d) Means of injury *Shot in abdomen*23. Signature *Robert L. Frazier* M.D.Date signed *Oct. 7 1943*

G 08903

BALTIMORE CITY HEALTH DEPARTMENT

G 08903

CERTIFICATE OF DEATH *94a*

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1721 Druid Hill Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *14*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1721 Druid Hill Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert Bowser

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

*C*6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1880

8. AGE:

Years

Months

Days

If less than one day

63

hr.

min.

9. Birthplace *Centreville, Md.*

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER12. Name *Horace Bowser*13. Birthplace *Md.*14. Maiden Name *Annie Cheers*15. Birthplace *Md.*16 (a) Informant *Mr. Albert Bowser*(b) Address *Centreville, Md.*17 (a) *Burial* (b) Date thereof *10-9-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Mt. Auburn Cem.*Location *Baltimore, Md.*18 (a) Funeral director *Mrs. Frances A. Hemsley*(b) Address *578 W. Biddle St.*

19 (a) (b)

*OCT 9 1943**Hamilton, Baltimore, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/7 1943 8:00 AM*21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *natural* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Thrombosis

Due to

Other Conditions *Stricture Urethra.*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature *Hugh B. McKeally M.D.*
Medical Examiner.*10/7/43*

G 08905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08905
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital 24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1742 Bell St. # 30

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

BABY GIRL EWING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1943

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Robert Ewing

13. Birthplace Maryland

14. Maiden Name Stella Scofield

15. Birthplace Minnesota

16 (a) Informant Mrs. Stella Ewing

(b) Address 1742 Bell St. # 30

17 (a) Burial (b) Date thereof 10-9-1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Glen Haven
Location A.A. Co. Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St.

19 (a) OCT 9 1943
(Date of registration)

Huntington Hillman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-1943 at 9:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5-1943 to 10-8-1943, and that I last saw her alive on 10-8-1943.

Immediate cause of death

A telethrombosis.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. B. Ballina M.D.

Address St. Joseph's Hospital Date signed 10/8/43

correct age is especially important. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08906

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-076818

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 7 1943 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Robert Lee Grotz M.D.

Date signed

Oct. 7 1943

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08907

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

526 E. Lecher Ave. State Md

(c) Hospital or institution:

home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

60 years

2. USUAL RESIDENCE OF DECEASED:

(a) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(b) Street No.

(If rural give location)

(c) Citizen of foreign country?

If yes, name country

Yes or No

3 (a) FULL NAME

Antonina Marzhi

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 7 1943 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13, 1943, to Oct 7, 1943, and that I last saw him alive on Oct 6, 1943.

Immediate cause of death

arteriosclerotic C.V. disease
Ch. myocarditis

Due to myocardial infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

none at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

Means of injury

Signature E. Schumacher

Address 642 E. East Ave Date signed 10/8/43

M. D.

4. Sex

Female

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

John Marzhi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

80

hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

John Marzhi
726 E. Curley St

17 (a) X

(b) Date thereof

10-11-43

(c) Cemetery or crematory

Location

St. Stanislaus
Hyattsville, Md

18 (a) Funeral director

(b) Address

John J. P. P. P.
2829 Hudson St

19 (a)

OCT 9 1943

(b)

Huntington Williams, M.D.

G 08908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08908
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3660 Falls Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

70 years

3 (a) FULL NAME

Mrs. Rachel Tibitha Burns

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

William Henry Burns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 1 - 1859

8. AGE: Years

Months

Days

If less than one day

84

5

hr.

min.

9. Birthplace

Carroll Co. Maryland

10. Usual Occupation

At Home

11. Industry or business

12. Name

Harry Appleby

13. Birthplace

Maryland

14. Maiden Name

Sarah Pickett

15. Birthplace

Maryland

16 (a) Informant

Mrs. Carrie Burns, Cole

(b) Address

3660 Falls Road

17 (a) Burial

(b) Date thereof

Oct. 9, 1943

(c) Cemetery or crematory

London Park

Location

Baltimore, Maryland

18 (a) Funeral director

Burgess' Funeral Home

(b) Address

3631 Falls Road

19 (a)

OCT 9

1943

Huntington, Williams, Mo

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3660 Falls Road

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 6, 1943, at 10 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 11 1943, to Oct 6 1943, and that I last saw her alive on Oct 6 1943.

Immediate cause of death

Cardiac Decompensation
intercurrent C.V.D.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Lawrence H. Hume

Address

3711 Falls Rd

Date signed

10-8-43

G 08909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08909

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give location)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of registration

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/43 to 10/7/43.

and that I last saw him alive on 10/7/43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Every item of information should be carefully supplied. With UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

08910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08910
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Wilkins & Cator Ave.*
(c) Hospital or institution: *St. Agnes*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD.* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)
(d) Street No. *4402 Leeds Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Raymond J. Chew

3 (b) If veteran, name war

3 (c) Social Security Account
No. *705-05-7977*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

4-15-1876

8. AGE:

Years

Months

Days

If less than one day

52

5

72

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

clerk

11. Industry or business

B + O. R. R.

FATHER
MOTHER

12. Name

William

13. Birthplace

Maryland

14. Maiden Name

Barbara Ruppel

15. Birthplace

Maryland

16 (a) Informant

Hospital record

(b) Address

Cator & Wilkins

17 (a)

B

(b) Date thereof

10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ken Catholic

Location

Old Avenue Rd.

18 (a) Funeral director

John R. Henry

19

2422 Level Ten Ave

(Date rec'd by registrar)

10/9/43

VB 158

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 7 1943, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 2 1943* to *Oct 6 1943*, and that I last saw him alive on *Oct 6 1943*

Immediate cause of death

Bilateral lobar pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Alfred H. Harrison

Steffen Hogg

Date signed *10-9-43*

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

08911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08911
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 - 0 - 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1028 N. Sansbury Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ellen Marie Holland

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or

divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) June 16 - 1935

8. AGE: Years Months Days If less than one day

8

3

20

hr.

min.

9. Birthplace

Baltimore, MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Sidney Holland

13. Birthplace

MD

MOTHER

14. Maiden Name

Evelyn Hughes

15. Birthplace

S.C.

16 (a) Informant

Evelyn Holland

(b) Address

1028 N. Sansbury St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 9, 1943

(c) Cemetery or crematory

Mt Zion

Location

18 (a) Funeral director

Mrs Katie R Williams

(b) Address

322 N. Schenck St

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams

23. Signature

Huntington Williams

Date signed

10-7-43

Medical Examiner.

M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 6 -

1943, at 8²⁰ P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-6-43 at

8 P.M.

(b) Where did injury occur?

1028 N. Sansbury St

(c) Did injury occur at home, on farm, industrial place, in public

place? Home

While at work?

No

(d) Means of injury Fall out of 3rd fl. window

OCT 9 1943

G 08912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08912
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 701 Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country?

No.

Yes or No

If yes, name country

3 (a) FULL NAME

Lee Baxter

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

Oct. 2, 1918

8. AGE: Years

25

Months

Days

5

If less than one day

hr.

min.

9. Birthplace

Summerton, S.C.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

John Baxter

13. Birthplace

Summerton, S.C.

MOTHER

14. Maiden Name

Janett Fludd

15. Birthplace

Summerton, S.C.

16 (a) Informant

Natie Brinson

(b) Address

701 N. Carrollton Ave.

17 (a)

Burial

(b) Date thereof

Oct. 9, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

Family lot
Summerton, S.C.

18 (a) Funeral director

Mrs. Lee, W. Holland

(b) Address

1631 Pineapple Hill Ave.
Washington, D.C.

19

OCT 9 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-7-431943 at 7:15 A. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wounds of Head, entering
Brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10-7-43 at 7:30 A M.(b) Where did injury occur? 701 Carrollton Ave.

(c) Did injury occur at home, on farm, industrial place, in public

place? HomeWhile at work? No(d) Means of injury Revolver

23. Signature

Howard J. Mulderis

M.D.

Date signed 10-7-43

Medical Examiner.

08913

AB#76811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 08913

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

1 Yr-17 days

(e) Length of stay in Baltimore (yrs., mos., or days)

?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3131 Hanover St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary McPhie

or

Mary Burke

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Widow

6 (b) Name of husband or wife

Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 25-1866

8. AGE: Years

76 77

Months

9

Days

9

If less than one day

hr.

min.

9. Birthplace Texas

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

?

13. Birthplace

?

14. Maiden Name

Mary Dunlap

15. Birthplace

Texas

16 (a) Informant Baltimore City Hospitals

(b) Address

Records

17 (a) (Burial, cremation, or removal)

(b) Date thereof 10 11 43

(month) (day) (year)

(c) Cemetery or crematory

Location

Sacred Heart
Garman Hill Rd

18 (a) Funeral director

(b) Address

J. J. Zahner & Sons
1318 1/2 Light St

19 (a) 10/9/43 (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1943 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-17 1942, to 10-4 1943.

and that I last saw her alive on 10-4 1943.

Immediate cause of death

Coronary Occlusion

Due to

her Arteriosclerosis

Due to

Hypertensive C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-10-43 - 9-24-43

Major findings of operation: Aneurysm

Extraction

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Anna B. Webb

Address

Baltimore City Hosp

Date signed

M. D.

10-7-43

Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH567
ST680 9
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **7 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **7 days**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Iceland** (b) County _____
(c) City or town **Halfnarstraeti #2, Isafjordur**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **Halfnarstraeti #2**
(If rural give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country _____

3 (a) FULL NAME **ANNA INGVARSDOTTIR**

3 (b) If veteran, name war

3 (c) Social Security Account
No. --

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or divorced.
Married6 (b) Name of husband or wife **Jonas Tomasson**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **April 8, 1900**8. AGE: Years Months Days If less than one day
43 **5** **28** hr. min.9. Birthplace **Isafjordur, Iceland**
(Town, county, and state)10. Usual Occupation **Housewife**

11. Industry or business

12. Name **Ingrar Vigfusson**13. Birthplace **Isafjordur, Iceland**14. Maiden Name **Sigradur Arnadottir**15. Birthplace **Iceland**16 (a) Informant **Records, U.S. Marine Hospital**(b) Address **Baltimore, Maryland**17 (a) **Cremation** (b) Date thereof **10-7-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Greenmount**
Location **Greenmount ave**18 (a) Funeral director **R. A. Odes**(b) Address **4644 York Rd.**19 (a) **10/9/43**
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **October 6,** 19 **43**, at **10:20** AM21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 29, 1943** to **Oct. 6, 1943** and that I last saw her alive on **Oct. 6, 1943**

Immediate cause of death

Atalectasis, with marked edema of both lungsDue to **Meningioma, lt. temporal lobe of brain**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **10/2/43**Major findings of operation **Bilateral occipital trephines for ventriculography; craniotomy; exc. of tumor.**
of autopsy: **as above**

PHYSICIAN

Underline the death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature

Address **US Marine Hospital** Date signed **10/9/43**
Baltimore, Md.

G 08916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 186a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *19 mos*(e) Length of stay in Baltimore (yrs., mos., or days) *3 years*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *3751 St Margaret*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME *BENJAMIN F. JOHNSON*

3 (b) If veteran, name war

3 (c) Social Security Account
No. *2*

4. Sex

m

5. Color or race

*w*6 (a) Single, married, widowed, or
divorced. *Married*6 (b) Name of husband or wife *Sellie Ann Johnson*

6 (c) If alive, give age + years

7. Birth date of deceased (mo., day, yr.)

about 1871

8. AGE:

Years

Months

Days

If less than one day

about 72

hr.

min.

9. Birthplace

Va

10. Usual Occupation

Foreman

11. Industry or business

Bethlehem Fairfield St

FATHER

12. Name

Julian Johnson

13. Birthplace

Va.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Va.

16 (a) Informant

Mrs W. S. Beal

(b) Address

408 Park St, Charlottesville

17 (a)

Burial

(b) Date thereof

10/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Methodist

Location

Sevierville Va.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

10/19/43

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 9* 19 *43* at *10 A.M.*21. I HEREBY CERTIFY, That I took charge of the remains described
above, held an *inquest* thereon and from the evidence
(Autopsy or Inquiry)obtained by said *inquest* find that said deceased came
(Autopsy or Inquiry)
to *his* death on the day stated above.

Immediate cause of death

Fracture of skull

Due to

Due to

Other Conditions *no*

(Include pregnancy within 3 months of death)

Date of operation

no

Major findings of operation:

of autopsy: *no*22. If death was due to external causes, fill in the following: *29/6*(a) Accident, suicide, or homicide *accident*

(b) Date of occurrence

10-8-43 at 2 P.M.

(c) Where did injury occur?

Bethlehem, Fairfield

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? *industrial* While at work? *yes*
(Specify type of place)(e) Means of injury *Fall from scaffold*23. Signature *W. S. Beal* M.D.Date signed *12-9-43* Medical Examiner.

G 08917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46M

G 08917

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Western Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1836 E. Madison St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sidberry Barnes or Barnes Sidberry (Sidbury)

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. 216-09-7372

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or

divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-9- 50?

8. AGE: Years Months Days If less than one day

50 ?

?

?

hr.

min.

9. Birthplace N.C.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Mutual Chemical Co

12. Name John Sidberry or John Barnes

13. Birthplace N.C.

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospital

(b) Address Records.

17 (a) Shipment (b) Date thereof Oct. 10, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment

Location Mt. Pleasant C.

18 (a) Funeral director Robert H. Cysner

(b) Address 804 W. Caroline St.

19 (a) 10/9/43 (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1943 at 12:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5, 1943, to Sept. 5, 1943, and that I last saw him alive on Oct. 6, 1943.

Immediate cause of death

Ruptured aortic aneurysm
(undetermined origin)

Due to

Due to

Other Conditions Inanition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. G. P. P. P.

Address Balto. City Hosp. Date signed 10-10-43

Duration

7

8

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08918

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 902 E Belvedere Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

3 (a) FULL NAME

WILLIAM

F.

VOLMERHAUS

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. 2-2-01-8213

4. Sex

m

5. Color or race

W

6 (c) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Etta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

April 8-1895

8. AGE:

Years

Months

Days

If less than one day

48

6

0

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Asst Manager

11. Industry or business

Dickman Hight Pay Co.

12. Name

William F. Volmerhaus

13. Birthplace

Germany

14. Maiden Name

Amelia Batt Ray

15. Birthplace

Germany

16 (a) Informant

Etta F. Volmerhaus

(b) Address

902 East Belvedere Ave

17 (a) Burial

(b) Date thereof Oct 12-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

London Park

Location 7200 Rock Road

18 (a) Funeral director

William Boalson

(b) Address

1217 E Paul Street

19 (a) Date rec'd by registrar

10-9-43

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 902

E Belvedere Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 8 1943, at 2:30 AM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. J. Wallenwien M.D.

Date signed 10-9-43

Medical Examiner.

G 08919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08919

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1943 to Oct 8 1943.

and that I last saw her alive on Oct 6 1943.

Immediate cause of death

Cancer of the breast

Due to

Autism

Due to

Other Conditions

Scurvy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

1761 E. North Ave.

Date signed

10/9/43

Samuel LeRue

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2608 E. Hoffman St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Margaret E. March

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

widowed

6 (b) Name of husband or wife George March

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1856

8. AGE: Years Months Days If less than one day

86 9 13 hr. min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At Home

12. Name Anthony Holliday

13. Birthplace Ireland

14. Maiden Name Mary Ann O'Toole

15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Myers

(b) Address 2508 E. Hoffman St.

17 (a) Burial (b) Date thereof 10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul

OCT 10 1943 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2608 E. Hoffman St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8th 1943 4:30 PM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 17 1943 to Oct 8 1943
and that I last saw her alive on Oct 7 1943

Immediate cause of death

Leukemia?

Due to Usual Malicious

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [Signature] Date signed 10/11/43

Duration

1200

1700

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not omit age is especially important. Physicians: please write the cause of death clearly and legibly.

08921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08921

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 726 E. 35th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

John Ham Parr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Virginia Parr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace Balto Md.

(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

12. Name William Parr

13. Birthplace Md.

14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant Mrs. Bernard McCluskey

(b) Address 726 E. 35th St

17 (a) Burial (b) Date thereof 10/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery as-cemetery Parkwood

Location Parkville Md

18 (a) Funeral director William Cook - Inc

(b) Address 127 St. Paul St

19 (a) Huntington Williams, M.D. Registrar

OCT 10 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 726 E. 35th St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1943 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to Oct 9, 1943, and that I last saw him alive on 19

Immediate cause of death

Myocarditis

Due to

Due to

Other Conditions Asphyxia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Hugh Forsythe, M.D.

Address 424 E. North Ave Date signed 10.7.43

Duration

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 03922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08922
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2519 BROOKFIELD AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO.

(If outside city of large health, write RURAL and give town)

(d) Street No. 2519 BROOKFIELD AVE

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

SADIE JOFFE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1894

8. AGE:

Years

Months

Days

If less than one day

69

hr.

min.

9. Birthplace

Russia

(City, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Wolf

13. Birthplace

Russia

14. Maiden Name

Yehuda

15. Birthplace

Russia

16 (a) Informant

Mr. Bloom

(b) Address

2519 Brookfield Ave.

17 (a) Burial

(b) Date thereof 10-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Bellevue Memorial

Location

Baltimore & Annapolis Rd.

18 (a) Funeral director

John J. Jones, Inc.

(b) Address

1839 E. Baltimore St.

(c) Registrar

William M. R.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-43 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Oct 9 1943

and that I last saw him alive on Oct 9 1943

Immediate cause of death

coronary occlusion

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel H. H. H.

Address 1720 E. Baltimore Date signed 10/10/43

M. D.

OCT 10 1943

G 08923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08923

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3606 Park Hgts. Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Ethel Mae Brust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1880

8. AGE:

Years

Months

Days

If less than one day

63

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Teacher

11. Industry or business

FATHER
MOTHER

12. Name

Beane Furman Kessler

13. Birthplace

Russia

14. Maiden Name

Beane

15. Birthplace

Russia

16 (a) Informant

Ethel Brust

(b) Address

3606 Park Hgts. Ave

17 (a)

burial

(b) Date thereof

10-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Pine Grove

Location

18 (a) Funeral director

Jace Lewis Inc

(b) Address

1739 E. Balto. St

19 (a)

(Date received by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3606 Park Hgts. Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 9

1943 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 8/12 1943 to 19

and that I last saw him alive on 10/8 1943

Immediate cause of death

Myocardial Infarction

Duration

Due to

Coronary Thrombosis 6/6

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Samuel J. Glickman

Address

2331 E. Baltimore St

Date signed

10/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 10 1943

G 08924

BALTIMORE CITY HEALTH DEPARTMENT

G 08924

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

VB 184

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 9

1943, at 12:17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1943, to Oct. 9 1943, and that I last saw him alive on Oct. 9 1943.

Immediate cause of death

Pulmonary Edema

Due to ? Acute Coronary Occlusion

Due to Hypertensive & Atherosclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied.

WITH UNFADING INK.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08925

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St Rutland Ave

(c) Hospital or institution:

Linai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1814 E. Fairmount Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Abraham Kurland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Sarah Kurland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Humming Peder

11. Industry or business

12. Name

13. Birthplace

Russia

14. Maiden Name

15. Birthplace

Russia

16 (a) Informant

Boy. Franelle

(b) Address

1814 E. Fairmount Ave

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

10-10-43

(c) Cemetery or crematory

St. Lawrence Mt. Carmel

Location

18 (a) Funeral director

Joe Peters Inc

(b) Address

1430 E. Balt. St

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/8/

1943 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/1943 to 10/5/1943, and that I last saw him alive on 10/5/1943.

Immediate cause of death

Myocardia

Due to

Coronary artery disease

Due to

Arteriosclerosis

Other Conditions

Post operative gastric ulcer

Date of operation

9/25/43

Major findings of operation

Ulceration Stomach

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

W. C. C. C.

Address Linai Hospital signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08926

Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>2010 BROOKFIELD AVE</u> (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md.</u> (b) County (c) City or town <u>Balti</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>2010 Brookfield Ave</u> (If rural, give location) (e) Citizen of foreign country? (Yes or No) If yes, name country	
3 (a) FULL NAME <u>JACOB DEBUSKEY</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced <u>Married</u>	
6 (b) Name of husband or wife <u>Maryne Schwartzman</u> 6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Sept 30-1881</u>			
8. AGE: Years <u>62</u> Months <u>11</u> Days <u>8</u> If less than one day hr. min.			
9. Birthplace <u>Balti</u> (Town, county, and state)			
10. Usual Occupation <u>Ret.</u>			
11. Industry or business			
12. Name <u>Charles Debuskey</u>			
13. Birthplace <u>Russia</u>			
14. Maiden Name <u>Mary-</u>			
15. Birthplace <u>Russia</u>			
16 (a) Informant <u>Mary Debuskey</u>			
(b) Address <u>2010 Brookfield Ave</u>			
17 (a) <u>Burial</u> (Burial, cremation, or removal) (b) Date thereof <u>10-10-43</u> (month) (day) (year)			
(c) Cemetery or crematory <u>B'nai Israel</u>			
Location <u>North Ave</u>			
18 (a) Funeral director <u>Joel Harris Inc</u>			
(b) Address <u>1439 E. Balt. St.</u>			
19 (a) <u>10-10-43</u> (Date rec'd by registrar) (b) <u>Huntington Williams MD</u> (Signature)			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>10-8</u> 19 <u>43</u> , at <u>1 P.</u> M			
21. I certify that death occurred on the date above stated; that I attended deceased from <u>July 18 1940</u> to <u>Oct 4</u> 19 <u>43</u> , and that I last saw him alive on <u>Oct 4</u> 19 <u>43</u> .			
Immediate cause of death <u>Coronary infarction</u>		Duration	
Due to <u>Ch Myocarditis</u>			
Due to <u>Ch Coronary Sclerosis</u>			
Other Conditions			
of autopsy:			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)			
(e) Means of injury			
23. Signature <u>A. L. Hornatemi</u> M. D.			
Address <u>737 Airport St</u> Date signed <u>10/8/43</u>			

G 08927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08927

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3305 Doelfield

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3305 Doelfield
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Gerdeni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Benjamin S.

6 (c) If alive, give age 6 years

7. Birth date of deceased (mo., day, yr.)

Aug 8 1887

8. AGE:

Years

Months

Days

If less than one day

56

1

29

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Michael Sansburgh

13. Birthplace

Russia

MOTHER

14. Maiden Name

Jennie Kellman

15. Birthplace

Russia

16 (a) Informant

Benjamin Gerdeni

(b) Address

3305 Doelfield

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof 10-10-43

(month) (day) (year)

(c) Cemetery or crematory

Southern Ave

Location

Southern Ave

18 (a) Funeral director

Jack Lewis

(b) Address

1139 E. Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct - 7 1943, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May - 10 1942 to Oct 7 1943 and that I last saw her alive on Oct 7 1943

Immediate cause of death

Carcinoma of Breast

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

May - 10 1942

Major findings of operation

Pischa

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dante Dranler

Address

1222 Lee

Date signed

10/7/43

G 08928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08928

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2926 Miles Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life!

2. USUAL RESIDENCE OF DECEASED:

(a) City Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2926 Miles Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Jesse Carter

3 (b) If veteran, name war

3 (c) Social Security Account

No. 220-22-6469

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Rosie Carter

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 20, 1882

8. AGE: Years Months Days If less than one day

61 3 18 hr. min.9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Davis Carter13. Birthplace Maryland14. Maiden Name Lillie Ford15. Birthplace Maryland16 (a) Informant Ella M. Lennia(b) Address 2926 Miles Ave.17 (a) Burial (b) Date thereof Oct 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or St. MarysLocation Hampden18 (a) Funeral director Cohenow & Sonovan(b) Address 36 N. 17th St.19 10 1943 Thur

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1943, at 9:25 A.21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to this death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH ArterioscleroticCardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner

Date signed October 7, 1943

G 08930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 810 W. 34th St.
 (c) Hospital or institution Franklin Square Hosp.
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
 (e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 810 W. 34th St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

BURLAND, ROBERT M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or divorced.6 (b) Name of husband or wife THIRZA BURLAND

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-1872

8. AGE: Years Months Days If less than one day

701016hr.min.9. Birthplace Ireland, Dublin
(Town, county, and state)10. Usual Occupation Retired

11. Industry or business

12. Name William Burland13. Birthplace Ireland14. Maiden Name Margaret Marsh15. Birthplace Ireland16 (a) Informant Mrs. Samuel Simkins(b) Address 810 W 34th St17 (a) Burial (b) Date thereof Oct 11/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or ossuery Meadowridge
Location Wash. Blvd.18 (a) Funeral director Cheney & Sonoran(b) Address 3615 17th Chestnut Ave19 (a) 10 1943 (b) Harriet M. Williams
(Entered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-43 19 43

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1943 to 10-8 1943, and that I last saw him alive on 10-8-43-19

Immediate cause of death

Carcinoma, recurrent, of
larynx & invasion of
pharynx

Due to

1st operation 8 yrs
ago for same disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none recent

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. P. FriedmanAddress 1319 Light St. Date signed 10/8/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08931
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3314 + Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County, _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Brookfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Mrs. Mary Savelovitz

3 (b) If veteran, name was

3 (c) Social Security Account No. _____

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Harry Savelovitz

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1880

8. AGE: Years 63 Months 7 Days 30
If less than one day _____ hr. _____ min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Jacob Eickson

13. Birthplace Russia

MOTHER

14. Maiden Name Lena Newhouse

15. Birthplace Russia

16 (a) Informant Mr. Morris Savelovitz

(b) Address 2213 Brookfield Ave.

17 (a) Burial (b) Date thereof 10-18-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Progras Cem

Location Harristown Pa.

18 (a) Funeral director Harry H. Zinke

(b) 1 E. Edmondson Ave

19 (a) Oct 10 1943 (b) Sanatogen Williams

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1943 at 1:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to Oct 8 1943, and that I last saw her alive on Oct 8 1943.

Immediate cause of death

skull fracture +
brain injury

Due to

fell down cellar steps

Due to

Other Conditions fracture of st. forearm

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Oct 5 at 1:35 AM

(c) Where did injury occur? Baltimore - 2213 Brookfield Ave.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no

(Specify type of place)

(e) Means of injury fell down cellar steps

23. Signature James H. McCosh M. D.

Address Union Memorial Hospital Date signed 10-9-43

Approved by Howard J. Molnar, M.D.

NEVER WRITE FAINTLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12049
G 08932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G 08932

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1517 Hazel St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt (If outside city or town limits, write RURAL and give town)

(d) Street No. 1517 Hazel St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Josefa Jirka (Jirka)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Albert Jirka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 5, 1875

8. AGE: Years Months Days

If less than one day

68 3 3 hr. min.

9. Birthplace

Austria / Hungary

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

FATHER

12. Name

Louis Hopacch

13. Birthplace

Austria

MOTHER

14. Maiden Name

Not known

15. Birthplace

Austria

16 (a) Informant

Louis Jirka

(b) Address

1517 Hazel St

17 (a) Burial

(b) Date thereof Oct 11 / 45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Feder Hill

Location

Balt. Md

18 (a) Funeral director

Smith & Son

(b) Address

800 Y. Calhoun St

19 (a) Registrar

Huntington Williams

19 (b) Date

Oct 10 1945

19 (c) Signature

Huntington Williams

19 (d) Address

1009 Rivington Way

19 (e) Date signed

Oct 10 1945

19 (f) Signature

P. J. Grimaldi

19 (g) Address

1009 Rivington Way

19 (h) Date signed

Oct 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1945, 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945 to Oct. 1945 and that I last saw her alive on Oct. 9 1945.

Immediate cause of death

Carcinoma of Gall Bladder and Liver.

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation 1945

Major findings of operation: Finding

of above

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature P. J. Grimaldi

Address 1009 Rivington Way

Date signed Oct 10 1945

19 (h) Signature

19 (i) Address

19 (j) Date signed

19 (k) Signature

19 (l) Address

19 (m) Date signed

19 (n) Signature

19 (o) Address

19 (p) Date signed

P. J. GRIMALDI

9-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-83973

08933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08933

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

3 (a) FULL NAME

DANIEL J. SCANLAN

3 (b) If veteran, name war

3 (c) Social Security Account
No. 217-07-0357

4. Sex
M

5. Color or race
W

6 (a) Single, married, widowed, or divorced.
Widower

6 (b) Name of husband or wife

OLIVE SLATER

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) May 16 1873

8 AGE: Yrs. 70 Months 4 Days 24 hr. min.

9. Birthplace

Canada

10. Usual Occupation Sec. of Iron Workers Union

11. Industry or business

12. Name Daniel Scanlan (SCANLAN)

13. Birthplace Canada

14. Maiden Name Catherine X. Kelly

15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals

(b) Address Records 1411/43

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 350 N. Gay St.

(e) Citizen of foreign country (If yes, name country) Canada

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1943, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1943 to 10/8 1943 and that I last saw him alive on 10/8 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

?

3 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08934

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md(b) County Kent(c) City or town Chester

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Natalie Roe

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife

Winfield Roe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 6 - 1915

8. AGE:

Years

Months

Days

If less than one day

412843

hr.

min.

9. Birthplace

Chester Kent Co Md

(Town, county, and state)

10. Usual Occupation

House Keeper

11. Industry or business

FATHER
MOTHER

12. Name

Claude J. Lloyd

13. Birthplace

Quantico Md

14. Maiden Name

Lela Jones

15. Birthplace

Chester Md

16 (a) Informant

John Williams

(b) Address

Exton Md

17 (a)

Burial

(b) Date thereof

Oct 12 - 43

(Burial, cremation, or removal)

(month) (day) (year)

Cemetery or crematory

Stroms Valley Bur

Location

Exton Md

18 (a) Funeral director

E. W. Lagorceau

(b) Address

1003 N. Baltimore St

OCT 10 1943

(b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 9 -1943, at5:45 P M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Crushed Chest, TraumaticDue to Respiratory FailureInt cutaneous emphysemaOther Conditions Multiple fractures, contusions& abrasions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury 10-7-43 at2:25 A M(b) Where did injury occur? Foggy - Illinois St

(c) Did injury occur at home, on farm, industrial place, in public

place? Public While at work? No(d) Means of injury Passenger - collision, auto vs trolley23. Signature Thomas J. Wallace M.D.Date signed 10-10-43 Medical Examiner.

G 08935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08935

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

5416 Summerfield

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

Life

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5416 Summerfield

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Eugene Marie Lohrle

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Rene Lohrle

6 (c) If alive, give age

37 years

7. Birth date of deceased (mo., day, yr.)

Aug. 6 1909

8. AGE:

Years

34

Months

2

Days

1

If less than one day

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Jas. J. Henkel

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Mary Napfel

15. Birthplace

Baltimore

16 (a) Informant

Mary A. Rodenshaft

(b) Address

6805 Beach a

17 (a)

Burial

(b) Date thereof

Oct 11, 43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

S. Walter May

(b) Address

619 N. Boulder St.

19 (a)

10-1843

(b)

Huntington Williams, M.D.

Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 7, 1943, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1943, to Oct. 7, 1943, and that I last saw her alive on Oct. 6, 1943.

Immediate cause of death

Subarachnoid hemorrhage

Due to

Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

S. H. S. S. S. S.

23. Signature

2878 Harford Rd

Date signed

10-7-43

G 08936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08936

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Kelkins & Caton Aves.*

(c) Hospital or institution:

St. Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *410 Hazlett Ave.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Clara L. Upman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Hubert Lawrence*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *5-6-86*

8. AGE: Years Months Days If less than one day

57 5 3 hr. min.9. Birthplace *Maryland*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Henry (de.)*13. Birthplace *Md.*14. Maiden Name *Matilda (de.)*15. Birthplace *Md.*16 (a) Informant *Hospit Record*

(b) Address

17 (a) *Funeral* (b) Date thereof *10-12-43*
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematorium *Catholic*Location *East Mt.*18 (a) Funeral director *George A. Furler*(b) Address *Fuller & Furler**10-1943* (Date of registration)*Thurston Williams, M.D.* (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 9 1943* at *9:55 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *10/1 1943* to *10/9 1943*, and that I last saw her alive on *10/9 1943*.

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *William Roschey*Address *St. Agnes Hosp.* Date signed *10/12/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

D08937

G 08937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93E 908937

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 N. Charles

St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. mos.

How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Katharine Duke

If U. S. Veteran specify WAR.

(a) Residence: No. 2125 N. Charles

St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX female	4. Color or Race white	5. Single, Married, Widowed, or Divorced (write the word) single
------------------	---------------------------	---

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb. 10, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	25	27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. home duties

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) St. Mary's County Md.

13. NAME George Duke

14. BIRTHPLACE (city or town) St. Mary's County Md.

15. MAIDEN NAME Annie E. Hebb

16. BIRTHPLACE (city or town) St. Mary's Co. Md.

17. INFORMANT Richard Hebb
(Address) 702 Northern Parkway

18. BURIAL, CREMATION, OR REMOVAL

Place Poplar Hill Cem'ty Date 10/11/43

St. Mary's Co.

19. UNDERTAKER John D. Mitchell & Sons, Inc.
(Address) 1928 Butaw Place

20. FILED OCT 11 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 7, 1943

22. I HEREBY CERTIFY. That I attended deceased from

July 20, 1943, to Oct 7, 1943

I last saw him alive on Oct 7, 1943 Death is said

to have occurred on the date stated above, at 4 P. M.

The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset
July 1943

Other contributory causes of importance:

Hemiplegia

Was an operation performed?

Date of

For what disease or injury?

Name of operation

Date of

What test confirmed diagnosis? Lead Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

2105 N. Charles St.

M. D.

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate.

v b s

G 08933

G 08938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 83-a 908938

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Park Ave. (Baptist Home) Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 1 yr mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Frances J. Whitmarsh

If U. S. Veteran

specify WAR

(a) Residence: No. 1615 Park Ave.

(Usual place of abode)

St. Ward

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female	4. Color or Race white	5. Single, Married, Widowed, or Divorced (write the word) single
------------------	---------------------------	---

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 6, 1863

7. AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	79	11	2	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Md.

13. NAME George Whitmarsh

14. BIRTHPLACE (city or town) ? (State or country)

15. MAIDEN NAME Elizabeth A. Ijams

16. BIRTHPLACE (city or town) ? (State or country)

17. INFORMANT Baptist Home Records (Address) 1615 Park Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Druid Ridge Cem'ty Date 10/11/43 19

19. UNDERTAKER Sch. J. Mitchell & Sons, Inc. (Address) 4900 Eutaw Place

20. FILED 06 11 1943 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 8 43

22. I HEREBY CERTIFY, That I attended deceased from Sept 21 43 to Oct 8 43

I last saw her alive on Oct 5 43 Death is said to have occurred on the date stated above, at 2 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset 9-21-43

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation Clinical Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

W. R. Johnson M. D.
Medical Arts Bldg.

OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08939
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1218 Madison Ave*

(If rural give location)

(e) Citizen of foreign country? *No* (If yes, name country)

3 (a) FULL NAME

Frank Motley

3 (b) If veteran, name war

3 (c) Social Security Account

No. *220-14-8667*

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3-19-1885*

8. AGE:

Years

Months

Days

If less than one day

58

4

8

6

18

hr.

min.

9. Birthplace *Danville, Va.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Robert L. Motley*

13. Birthplace *Danville, Va.*

14. Maiden Name *Clara Scott*

15. Birthplace *Danville, Va.*

16 (c) Informant *Mildred Motley*

(b) Address *1515 Madison Ave.*

17 (a) *Burial* (b) Date thereof *Oct. 10, 1943*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Arbutus Mem. Ch.*

Location *Baltimore Co. Md.*

18 (a) Funeral director *Mrs. Geo. W. Hubbard*

(b) Address *1631 Primrose Hill Ave*

OCT 11 1943 (b) *Huntington Hill*

VS 146

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 7* 1943. *05* *2* M

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept. 30* 1943, to *Oct. 7* 1943, and that I last saw him alive on *Oct 7* 1943.

Immediate cause of death

Chronic Nephritis

Due to *Essential Hypertension*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *G. B. Canfield*

Address *Provident Hospital* Date signed *10-7-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30-P

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: *Balkon + Fayette Sts.,*
(c) Hospital or institution: *Franklin Square Hosp.*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*
(e) Length of stay in Baltimore (yrs., mos., or days) *42 yrs. life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)
(d) Street No. *3506 Actna Ave.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Vincent Gabrieliatis

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *216-18-6447*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

Julia Trauner

6 (c) If alive, give age

39 years

7. Birth date of deceased (mo., day, yr.)

11-17-1901

8. AGE: Years

42

Months

10

Days

19

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Welder

11. Industry or business

Shipyard

12. Name

Felix

13. Birthplace

Lithuania

14. Maiden Name

Josephs

15. Birthplace

Lithuania

16 (a) Informant

Mrs. Julia Gabriel

(b) Address

3506 Actna Ave.

17 (a)

Burial

(b) Date thereof

10/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Black Rock

18 (a) Funeral director

James J. Kelly

(b) Address

1600 Collins St.

19

OCT 11 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 6* 1943, at *10:30 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 4* 1943, to *Oct 6* 1943, and that I last saw him alive on *Oct 6* 1943.

Immediate cause of death

Coronary occlusion

Due to

Myocarditis

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Paul Schenck*

Address *2501 Arnpur*

Date signed *10/6/43*

Duration

3 days

1 year(?)

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 089411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 089411

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **3339 Avondale Avenue**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **27**
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County **Baltimore**
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **3339 Avondale Avenue**
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Florence E. Neisser

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife **George W. Neisser**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan. 10, 1870**8. AGE: Years Months Days If less than one day
73 8 27 hr. min.9. Birthplace **Hull England**
(Town, county, and state)10. Usual Occupation **Housewife**

11. Industry or business

12. Name **G. A. Davis**13. Birthplace **Hull, England**14. Maiden Name **Unknown**

15. Birthplace

16 (a) Informant **George W. Neisser**(b) Address **3339 Avondale Avenue**17 (a) **Burial** (b) Date thereof **10-11-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Mt. Olivet**
Location **Baltimore, Maryland**18 (a) Funeral director **LORING BYERS**
(b) Address **3005 Park Heights Avenue**19 (a) **OCT 11 1943** **Huntington**
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 7, 1943** M21. I certify that death occurred on the date above stated; that I attended deceased from **June 1943** to **Oct 7 1943**, and that I last saw him alive on **Oct 5 1943**

Immediate cause of death

Acute Cardiac Dilatation

Duration

SuddenDue to **Chronic Mitral Endocarditis**Due to **Chronic Nephritis**Other Conditions **Hypertension**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **G. B. Burns** M. D.Address **7201 York Rd** Date signed **10-10-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08942

442430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08942

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.Y. (b) County

(c) City or town Rochester

(If outside city or town limits, write RURAL and give town)

(d) Street No. 8 Arlington Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Margaret Young

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6/25/25

8. AGE: Years

Months

Days

If less than one day

18

3

15

hr.

min.

9. Birthplace

N.Y.

(Town, county, and state)

10. Usual Occupation

Student

11. Industry or business

12. Name

Frederick Young

13. Birthplace

N.Y.

14. Maiden Name

Ruth Hart

15. Birthplace

N.Y.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) 10/14/43

(b) Date thereof

Burial

(Burial, cremation, or removal)

(month)

(day)

(year)

(c) Cemetery or crematory

Holy Sepulchre

Location

Rochester N.Y.

18 (a) Funeral director

John C. Macdonald

(b) Address

1900 East Ave

007 11-10

(Date rec'd by registrar)

William Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-10 1943 2:55 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-6 1943 to Oct-10 1943 and that I last saw him alive on Oct-10 1943

Immediate cause of death

Primary Tumor

Duration

7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-9-43

Major findings of operation: Primary Tumor

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harry V. Rizzi

Address Johns Hopkins Hosp

Date signed 10-10-43

VR 2

G 08944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08944
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 802 N. Calhoun St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

3 (a) FULL NAME

Martha J. Enniss

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 31-1886

8. AGE:

Years

Months

Days

If less than one day

5749hr.

min.

9. Birthplace

CinOhio

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

FATHER

12. Name R. Emory Enniss13. Birthplace Soldbury, Md.

MOTHER

14. Maiden Name Anna Sanders15. Birthplace Baltimore - Md.16 (a) Informant Miss Anna M. Enniss(b) Address 626 N. Fulton Ave17 (a) Burial (b) Date thereof 10/12/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount Cem.Location Baltimore Md.18 (a) Funeral director Charles J. Schwalb(b) Address 505 N. Monaca St.19 (a) OCT 11 1943 (b) Huntington Williams M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) Ind or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 802 N. Calhoun St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 1943, at 3:30 P M21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature Thomas J. Unelleis M.D.

Medical Examiner.

Date signed 10-10-43

G 08945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08945

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3910 E Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 74

3 (a) FULL NAME

Charles A Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Ida A Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 8 1864

8. AGE:

Years

Months

Days

If less than one day

74

1

0

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Pattern Maker

11. Industry or business

12. Name

Chas Fisher

13. Birthplace

MD

14. Maiden Name

Katharina Remboldt

15. Birthplace

MD

16 (a) Informant

Mrs Helen Fisher

(b) Address 3910 E Pratt St

17 (a) Burial, cremation, or removal

(b) Date thereof Oct 11 1943

(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Rural

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2004-8-11 Ave St

19 (a)

Oct 11 1943

Huntington

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3910 E Pratt St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 8 1943

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1943 to Oct 8 1943, and that I last saw him alive on Oct 8 1943.

Immediate cause of death

Acute Cardiac Dilatation

Due to

Cardiac hypertrophy & myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. V. Clift

Address

5010 Greenleaf Road

Date signed Oct 9 1943

G 08946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) Don

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JAMES

SELBY JR.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or
divorced.

-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

May 2, 1948

8. AGE:

Years

Months

Days

If less than one day

5

27

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

James Selby

13. Birthplace

Md.

14. Maiden Name

Dorothy Chatman

15. Birthplace

Md.

16 (a) Informant

James Selby

(b) Address

642 Haw St.

17 (a)

Burial

(b) Date thereof

Oct 11-48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

a. a. c. o., Md

18 (a) Funeral director

James Astor

(b) Address

142 W. Hill St

19 OCT 11 1948

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

642

Haw St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 9

1948, at 1:25 PM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

diarrhea, infarct

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

H. Z. Wollemacher

M.D.

Date signed 10-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08947
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 101 Wendover Road, Guilford
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) xxxxxxx
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Wendover Rd., Guilford
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country xxxxxxx

3 (a) FULL NAME

EDNA HOOK REQUARDT

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife John M. Requardt

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1880

8. AGE: Years Months Days If less than one day

about 63 0 2 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

NONE

12. Name Jacob W. Hook

13. Birthplace Baltimore, Md.

14. Maiden Name Anna Miller

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John M. Requardt, husband

(b) Address 101 Wendover Road, Guilford, City

17 (a) Burial (b) Date thereof Oct. 11, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount Cemetery

Location Green Mount at Oliver, Balto. Md.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Ave. (W.F. Wooden, Suc.)

19 (a) (b) Huntington Miller

(Name of registrar)

OCT 11 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1943 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Oct 9, 1943, and that I last saw her alive on Oct 8, 1943.

Immediate cause of death

CARCINOMA - STOMACH

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury Walter A. Backer

23. Signature

Address 1115 St. Paul St Date signed Oct 10, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08948

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Baltimore (b) County(c) City or town Sunderland

(If outside city or town limits, write RURAL and give town)

(d) Street No. 45 E. Main

(If rural give location)

(e) Citizen of foreign country? British subject (Yes or No)
If yes, name country

3 (a) FULL NAME

Salem Sabga

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Mrs. Rose Sabga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1893

8. AGE: Years Months Days If less than one day

49 10 14 hr. min.

9. Birthplace

Syria

(Town, county, and state)

10. Usual Occupation

Merchant

11. Industry or business

Own business

FATHER

12. Name

Tommy Sabga

13. Birthplace

Syria

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant Mrs. Stephanie Page Joye(b) Address 622 S. Main St. Lumberton, Pa.17 (a) Burial (b) Date thereof 10/11/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Olivet Cem.Location Balto., Md.18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Balto., Md.19 (a) OCT 11 1943 (b) Washington Hillman, Md.
Register

VB 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29-43 1943, at 2 P. M.21. I certify that death occurred on the date above stated; that I attended
deceased from Sept. 25 1943, to Sept 29 1943,
and that I last saw him alive on Sept 29 1943

Immediate cause of death

Lung abscess left.

Duration

7 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-29-43

Major findings of operations:

Lung abscess

of autopsy.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabella HarrisonAddress Church Home & Hospital Date signed 9-29-43 M. D.

G 08949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08949

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2722 Hugo Ave.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Hugo Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN ADAM LEONARD HEMMETER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Lillian E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/1883

8. AGE: Years 59 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Bethlehem Steel

12. Name Frederick Hemmeter

13. Birthplace Germany

14. Maiden Name Barbara Beck

15. Birthplace Hanover, Pa.

16 (a) Informant Mrs. Lillian E. Hemmeter

(b) Address 2722 Hugo Ave.

17 (a) Burial (b) Date thereof 10/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address 1943 Baltimore St. Williamsport

19 (a) (b) 0 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1943, at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1943, to Oct 8 1943, and that I last saw him alive on Oct 7 1943.

Immediate cause of death

Atherosclerosis

Due to Atherosclerosis Hypertension 1 mo

Due to 6th Intercostal lymphatics 1 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature J. S. Stevens

Address 2878 Harford Rd Date signed 10/8/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08950
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 132 W. Laf. Ave
(c) Hospital or institution: Judge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Alice C. Love

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 31st 1852

8. AGE: Years 91 Months 4 Days 8 If less than one day
hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Joseph K. Love

13. Birthplace York Pa.

14. Maiden Name Mary A. Guld

15. Birthplace Md.

16 (a) Informant Miss Lillian E. Perry

(b) Address Walport Apartments

17 (a) Burial (b) Date thereof 10/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or location Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) Oct 11 1943 Huntington William Cook Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 1943 at 7¹⁵ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27th 1943 to Oct 8th 1943, and that I last saw her alive on Oct 7th 1943

Immediate cause of death

Carcinoma of Stomach

Duration

3 months

Due to Intoxication

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature Wm Conrad Bode M. D.

Address 1900 Maryland Ave Date signed 10-10-43

G 08951

BALTIMORE CITY HEALTH DEPARTMENT

G 08951

64026

YA

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days)

2 yrs.
7 mos.
12 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 314 E. Lafayette Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frances Walker

3 (b) If veteran, name war

NU

3 (c) Social Security Account

No. NO 15

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1868

8. AGE: Years Months Days If less than one day

74

11 10

27 26

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation On relief

11. Industry or business

12. Name John Wakeland

13. Birthplace Md.

14. Maiden Name Eliza Mumma

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(RECORDS)

17 (a) Burial (b) Date thereof 10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) OCT 11 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 9 1943 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1941, to 10-9 1943, and that I last saw her alive on 10-9 1943.

Immediate cause of death

Uremia

Duration

?

Due to Nephrosclerosis

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy. As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Hall

M. D.

Date signed 10/11/43

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08952

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08952
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 301 N. Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

SARAH HARRIDAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1930

8. AGE: Years Months Days If less than one day

13

7

6

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Rudolph Harriday13. Birthplace Md.14. Maiden Name Laura Harriday?15. Birthplace Md.16 (a) Informant Mrs. Laura Harriday(b) Address 301 N. Stricker St.17 (a) Burial (b) Date thereof 10-12-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western StarLocation Balto. Md.18 (a) Funeral director Mrs. Frances Humbley(b) Address 578 W. Biddle St.

OCT 11 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 301 N. Stricker St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

8:30 A

20. DATE OF DEATH Oct. 9, 1943, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cachexia due to atrophy of cerebral cortex.Due to same undetermined

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. H. Williams M.D.Date signed 10-9-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08953

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08953

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3403 Du Pont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Du Pont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Kathryn D. Anastase

- 3 (b) If veteran, name war
None

- 3 (c) Social Security Account
No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

- 6 (b) Name of husband or wife George Anastase
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1900

8. AGE: Years 43 Months 8 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

12. Name James Dorsey
13. Birthplace Baltimore Md.

14. Maiden Name Catherine Burns
15. Birthplace Ireland

- 16 (a) Informant Miss Margaret J. Dorsey (Sister)
(b) Address 3403 Du Pont Ave.

- 17 (a) Burial (b) Date thereof Oct. 14, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto; Md.

- 18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave

- 19 (a) OCT 11 1943

Huntington Hill, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1943 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1943 to 10/10 1943, and that I last saw her alive on 10/10 1943.

Immediate cause of death

- Due to Diabetes Mellitus 2-3 yrs
Due to Intercurrent CV Disease 2 yrs
Due to Coronary Thrombosis 1-2 yrs
Other Conditions Central Embolism 1 Hour
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A. Wentworth M.D.
Address 4603 K Ave Date signed 10/11/43

G 08954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08954
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Monument & Rutland Ave*

(c) Hospital or institution:

Sinai Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *24 hr.*(e) Length of stay in Baltimore (yrs., mos., or days) *24 hr.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *209 S. Fremont Ave.*

(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Baby Girl Reiness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced

New born

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

1

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

New born

11. Industry or business

FATHER
MOTHER12. Name *Emanuel Reiness*13. Birthplace *Baltimore, Md.*14. Maiden Name *Evelyn Kaplan*15. Birthplace *Baltimore, Md.*16 (a) Informant *Evelyn Reiness*(b) Address *209 S. Fremont Ave*17 (a) *Burial* (b) Date thereof *Oct 11/49*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Belus Roadside*Location *Hamilton Ave*18 (a) Funeral director *Lot Reiness & Son*(b) Address *124-26 N. North Ave*19 (a) *Huntington Baltimore* (b) *1411 E. Euter R**OCT 11 1949*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 10 1949* *7:30 pm*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 9 1949* to *Oct 10 1949*, and that I last saw *her* alive on *Oct 10 1949*.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury

23. Signature *Wm B. Shapiro*

M. D.

Address *1411 Euter R* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08955

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08955
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Hattie Louise Holmes

3 (b) If veteran, name war

3 (c) Social Security Account

No. 240-22-3115

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Russell B. Holmes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1920

8. AGE:

Years

Months

Days

If less than one day

22

11

3

hr.

min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business Motor Electric Co.

FATHER

12. Name Harry P. Connolly

13. Birthplace N.C.

MOTHER

14. Maiden Name Addie Sue

15. Birthplace N.C.

16 (a) Informant Harry P. Connolly

(b) Address Fayetteville N.C.

17 (a) Burial (b) Date thereof Oct 11 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Greensboro N.C.

18 (a) Funeral director Leo B. Cook

(b) Address 1701-03 N. Patt. Park Ave

19 (a)

(b)

OCT 11 1943

Hattie Louise Holmes

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1909 Indor Place

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-1943 at 11 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bichloride of Mercury

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mercedes M.D.

Date signed 10-10-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Byrum 08956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08956

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument + Wayne St

(c) Hospital or institution:

Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1205 N. Broadway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary E. Byrum

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Robert L. Byrum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1883

8. AGE: Years Months Days If less than one day

60

-

27

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Charles Makin

13. Birthplace Ga.

MOTHER

14. Maiden Name

15. Birthplace Ga.

16 (a) Informant Robert L. Byrum

(b) Address 1205 N. Broadway St

17 (a) Burial (b) Date thereof 10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Balto. Md

18 (a) Funeral director Harry H. Shulze

(b) Address 4101 E. Broadway Ave.

19 OCT 11 1943

(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1943, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1943, Oct. 7, 1943, and that I last saw her alive on Oct. 7, 1943.

Immediate cause of death Bronchopneumonia + Pulmonary edema.

Duration

Due to Atherosclerotic CVD

2 days

Due to

Other Conditions Emphysema (Atherosclerotic), Portal Hypertension, Arteriosclerosis, etc.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Henry M. Murch

Address Sinai Hosp. Date signed Oct 7-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

08957

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08957
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address: Roland Park Apartments
 (c) Hospital or institution: none
 (d) Length of stay in hospital or inst. (yrs., mos., or days): 27
 (e) Length of stay in Baltimore (yrs., mos., or days): 50 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Md. (b) County: none
 (c) City or town: Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.: Roland Park Apartments
 (e) Citizen of foreign country: No (If rural give location) (Yes or No)
 If yes, name country:

3 (a) FULL NAME Ida Mengel Abbott

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Cornelius W. Abbott 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1867

8. AGE: Years 76 Months 4 Days 2827 If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Joseph Mengel

13. Birthplace Pa.

14. Maiden Name Mary Probasco

15. Birthplace New Jersey

16 (a) Informant C. W. Abbott, Jr.

(b) Address 641 W. University Parkway

17 (a) Burial (b) Date thereof 10/11/43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or cemetery: Doudon Park Location 3801 Frederick Avenue

18 (a) Funeral director John A. Mitchell & Sons, Inc. 1900 Eutaw Place

19 (a) OCT 11 1943 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1943, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26, 1945, to Oct 9, 1943, and that I last saw h.w. alive on Oct 9, 1943.

Immediate cause of death Carcinoma of stomach
ulcers (Adeno carcinoma)

Due to Generalized metastasis

Due to

Other Conditions Acute Myocardial Infarction
Angels Disease of Heart.
(Include pregnancy within 6 months of death)
Date of operation April 1945
Major findings of operation: Adeno carcinoma of body of stomach
of body of stomach
of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles E. Jones

Address 222 Wendover Road Date signed Oct 10-43 M. D.

Registered No.

VRS 150

08959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08959

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1934 N. Washington St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1828 N. Bond St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lida May LeFevre

3 (b) If veteran, name war

3 (c) Social Security Account
No. -----

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife **Wm. H. LeFevre**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan---1872**

8. AGE: Years **71** Months **9** Days **--** If less than one day
hr. min.

9. Birthplace **Baltimore Md.**
(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name **Chas. Streeper**

13. Birthplace **Balto. Md.**

14. Maiden Name **Amanda Lyons**

15. Birthplace **Balto. Md.**

16 (a) Informant **Mr. Harry LeFevre**

(b) Address **1828 N. Bond St.**

17 (a) **Burial** (b) Date thereof **Oct. 11/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Woodlawn Cem.**

Location **Balto. Md.**

18 (a) Funeral director **Philip Hewigsons**

(b) Address **2024 Orleans St.**

OCT 11 1943 (b) **Huntington** **William M. R.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 8th. 1943** 19 **11** **30** at **04** M

21. I certify that death occurred on the date above stated; that I attended deceased from **July 9 1942** to **Oct 8 1943**, and that I last saw him alive on **Oct 8 1943**.

Immediate cause of death

Infantile of age

Due to **Infantile**

Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury **Dr. Perry Carman MD**

23. Signature **Dr. Perry Carman MD**

Address **1701 N. Caroline** Date signed **Oct 9 1943**

PHYSICIAN

Underline the cause to which death should be charged statistically.

08960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08960

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-10-0108

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

64

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof 10-11-43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/10

1943 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1943 to 10/10 1943 and that I last saw him alive on 10/10 1943

Immediate cause of death

Myocardial infarction

Due to Coronary Thrombosis

Due to Atherosclerotic CVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm. R. Gault

Address

Sinai Hospital

Date signed 10/10/43

OCT 11 1943

VB 180

08961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08961

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account
No. *118-10-8024*

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*(b) Date thereof *10-13-43*

(c) Cemetery or crematory

(d) Location

18 (a) Funeral director

(b) Address

(c) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 10, 1943 at 1:30 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 10, 1943 to Oct. 10, 1943*, and that I last saw him alive on *Oct. 10, 1943*.Immediate cause of death *Cardiac Failure*

Duration

Due to *Coronary Occlusion*Due to *Arteriosclerotic CVD*

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address *Swain Road* Date signed *10/14/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08962
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

5104 WOOLVERTON AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County

(c) City or town

BALTO

(d) Street No.

5104 WOOLVERTON AVE

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

JENNIE SHUGAM

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6 (b) Name of husband or wife

BARNETT

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

1875

8. AGE:

Years

Months

Days

If less than one day

68

hr.

min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER
MOTHER

12. Name

VICTOR TAYLOR

13. Birthplace

RUSSIA

14. Maiden Name

MILDRED

15. Birthplace

RUSSIA

16 (a) Informant

(b) Address

17 (a)

BURIAL

(b) Date thereof

10-11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

ROSEDALE

Location

Phila. Rd. & Hamilton Ave

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1439 E. Balto. St

19

OCT 11 1943

(Date rec'd by registrar)

William Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-11-43

19

3³⁵ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1943 to Oct 11 1943.

and that I last saw him alive on Oct 11 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

May 5 - 1943

Major findings of operation

Cholelithiasis, Co of

of autopsy: Pancreas

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2128 W. North

Date signed

08963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08963
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 424 N. Gilmore Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ELINORE HILL

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3/30/42

8. AGE:

Years

Months

Days

If less than one day

1

18

8

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Albert Hill

13. Birthplace

Md.

14. Maiden Name

Catherine Bentz

15. Birthplace

16 (a) Informant

Catherine Hill

(b) Address

424 N. Gilmore St.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date of

10-12-43
(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

William A. Jackson

19 (a) 11-1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1943, 3:40 P.M.

21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Carbon Monoxide asphyxiation.

House afire.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury October 8, 1943 M.

(b) Where did injury occur? 424 N. Gilmore St.

(c) Did injury occur at home, on farm, industrial place, in public
place? Home While at work? No

(d) Means of injury Suffocation due to fire.

23. Signature N. L. W. Williams M.D.

Date signed 10-9-43

08964

BALTIMORE CITY HEALTH DEPARTMENT

G 08964

T.N

83871

CERTIFICATE OF DEATH 153

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1019 Wilnot Court

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Sorrentino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Duma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th, 1905

8. AGE: Years

38

Months

4

Days

2

If less than one day

hr.

min.

9. Birthplace Africa

(Town, county, and state)

10. Usual Occupation Welfare

11. Industry or business

12. Name Maury Sorrentino

13. Birthplace Italy

14. Maiden Name Vincenzia Di Pioto

15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Oct. 13, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore

18 (a) Funeral director

Pila Wiedefeld

(b) Address

914 Greenmount Ave

OCT 11 1943

(Date rec'd by Registrar)

(b) Hunterton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/10

1943, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1943 to 10/10 1943 and that I last saw him alive on 10/10 1943.

Immediate cause of death

Abdominal distention

Prostatic cancer

Due to

Prostatic cancer & effluvia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

P. H. Hall

Address

Red

Date signed

M. D.

10/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a G 08965
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) (b)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from to and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 11 1943

G 08966 HEALTH DEPARTMENT—CITY OF BALTIMORE

G 08966

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 3811 Hayward St. WARD 6)

2. FULL NAME

Ide May Shuttall Shamer

(a) RESIDENCE No.

3811 Hayward St. WARD 6

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 - 18607 AGE Years 83 Months 7 Days 27 If LESS than 1 day, hrs. 26 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jefferson Co W Va (State or country)10 NAME OF FATHER Josiah Watson11 BIRTHPLACE OF FATHER (city or town) Jefferson Co W Va (State or country)12 MAIDEN NAME OF MOTHER Rebecca Loke13 BIRTHPLACE OF MOTHER (city or town) Jefferson Co W Va (State or country)14 Informant Mrs Forrest Sechrist (Address) 3811 Hayward Ave15 Filed Wactonore - md 19 1943

MEDICAL CERTIFICATE OF DEATH

14 DATE OF DEATH (month, day, and year) 10/11 1943

17

HEREBY CERTIFY, That I attended deceased from 9/22 1943 to 10/10 1943, that I last saw her alive on 10/9 1943.and that death occurred, on the date stated above, at 6:50 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis
Hypertension
Malnutrition, fluid retention
2-3 yrs (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? at place of death
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Symptomatic(Signed) Henry C. Sechrist M. D.10/11, 1943 (Address) 3811 Hayward Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVANCECharlestown, West Virginia DATE OF BURIAL Oct. 11, 1943

20 UNDERTAKER

Loring Byers ADDRESS 5005 Oak

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08967

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2206 N. Howard St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Millie Downing (Mac Kentere)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Married

6 (b) Name of husband or wife

Freddie Downing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 8, 1916

8. AGE:

Years

Months

Days

If less than one day

27

0

-

-

hr.

min.

9. Birthplace

King William County Va.

(Town, county, and state)

10. Usual Occupation

Short order Cook

11. Industry or business

FATHER
MOTHER

12. Name

Charles Bampton

13. Birthplace

King William County Va.

14. Maiden Name

Mary Williams

15. Birthplace

King William County Va.

16 (a) Informant

Mary Williams

(b) Address

2206 N. Howard St.

17 (a)

Burial

(b) Date thereof

10-11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Calvary

Location

18 (a) Funeral director

G. Halstead

(b) Address

918 David Hill Ave.

19 (a)

Oct 11 1943

Registrar

Registrar

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 8

1943

at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1943 to 10/8 1943, and that I last saw him alive on 10/8 1943.

Immediate cause of death

Cardiac failure

Due to

embolism?

Due to

Other Conditions

Transfusion reaction

Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

10-6-43

Major findings of operations

fibromyoma

Tubo-ovarian abscess

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John J. Williams, M.D.

Address Union Hospital

Date signed 10-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08968

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1214 Light St.

(c) Hospital or institution
S. Ball's Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

3 (a) FULL NAME

FLORENCE M. ELLENDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife

GEORGE

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

1885

8. AGE:

Years

Months

Days

If less than one day

58

hr.

min.

9. Birthplace

POLAND

(Town, county, and state)

10. Usual Occupation

HOUSEWIFE

11. Industry or business

12. Name

Unknown

13. Birthplace

Poland

14. Maiden Name

Unknown

15. Birthplace

Poland

16 (a) Informant

George Ellender

(b) Address

3503 Mt Pleasant

17 (a)

Burial

(b) Date thereof

10/13/43

(Burial, cremation, or removal)

(c) Cemetery or

New Cathedral

Location

4200 Old Federal Ave

18 (a) Funeral director

Stephen Teakowski

(b) Address

1000 S. Remond Ave

19 (a)

OCT 11 1943

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Balto

(c) City or town

Baltimore

If outside city or town limits, write RURAL and give town

Sheet No.

3503 Mt. Pleasant

(If rural, give location)

Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/10

1943

at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1943 to 10/10 1943.

and that I last saw him on 10/10 1943.

Immediate cause of death

Cerebral

hemorrhage

Due to

Hypertension

Due to

6 days

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

10/10

G 08969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08969

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave.

(c) Hospital or institution:

St. Agnes' Hospt.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Kirk Low Tate

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 2170 - 50 142

Sex

MaleWhite

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Adela H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1888

8. AGE: Years Months Days If less than one day

54499hr.min.

9. Birthplace

Virginia (Richmond)

(Town, county, and state)

10. Usual Occupation

unemployed

11. Industry or business

Electrician12. Name Oliver B. Tate13. Birthplace Va.14. Maiden Name Cora Lacy15. Birthplace Va.

16 (a) Informant

St. Agnes Hospital

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 13, 1948

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location

Pikesville, Md.18 (a) Funeral director W. J. TICHNER & SONS(b) Oct 11 1948

19 (a) (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2433 W. Lafayette Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at M21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1948 to Oct 10 1948 and that I last saw him alive on Oct 10 1948.

Immediate cause of death

Rupture of left ventricle

Duration

Due to Myocardial infarctionDue to Coronary Occlusion3 wks?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Alfred S. GannonAddress St. Agnes Hosp Date signed Oct 11 1948

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08970
AB-84184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Barnes St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Cornelius Wilson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Jessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1895

8. AGE: Years 48 Months 9 Days 20
If less than one day hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name James Wilson

13. Birthplace Va.

14. Maiden Name Alice Williams

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof Oct. 11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Gm.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Son

(b) Address 129 N. Caroline St.

19 (a) (b)

Oct 11 1943
Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1943 at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1942 to 10-8 1943, and that I last saw him alive on 10-8 1943.

Immediate cause of death

Heart failure

Duration

1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul H. H.

Address Aet

M. D.

Date signed 10/8/43

G 08971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08971

Registered No.

PLACE OF DEATH: *Warrington apt*
 (a) Baltimore City, Maryland
 (b) Street address *Warrington Apts*
 (c) Hospital or institution: *3908 N. Charles St*
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *3401 Greenway*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 24, 1882*

8. AGE: Years Months Days If less than one day

*61**5**11**hr.**min.*9. Birthplace *Baltimore Md*

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

12. Name *Charles A Vogeler*13. Birthplace *Baltimore*14. Maiden Name *Minnie A. Winter*15. Birthplace *Kentucky*16 (a) Informant *Carolyn B. Martin*(b) Address *5109 St Albans Way*17 (a) *Burial* (b) Date thereof *Oct 11 43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Mount

Location

*Balto Md*18 (a) Funeral director *Henry H. Jenkins & Co*(b) Address *McClure Park**OCT 11 1943*

(Date rec'd by)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 10* 1943, at 2:40 PM21. I certify that death occurred on the date above stated; that I attended deceased from *Dec* 1942, to *October 10* 1943, and that I last saw him alive on *October 10* 1943.

Immediate cause of death

*acute coronary occlusion*Due to *Arteriosclerosis**Hypertension*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Francis W. Black*Address *715 Park Ave*Date signed *10/11/43*

Duration

*1 1/2 hrs**Arteriosclerosis**hypertension*

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08972

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Subject age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 928 Street

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME

Mary Alice Tibbets

(MARY ALICE TIBBETTS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1862.

8. AGE: Years 80 Months 11 Days 4 2 3 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name Jonathan A. Hubbard.

13. Birthplace Baltimore, Md.

14. Maiden Name Ann Jane Deming

15. Birthplace Baltimore, Md.

16 (a) Informant Union Memorial Hosp

(b) Address

Rochester

17 (a) Burial. (b) Date thereof 10/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore City.

18 (a) Funeral director L. J. Van Lennep

(b) Address 441 Park Heights

19 (a) (b)

Registrar

1-1-1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 403 Mount Airy Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1943 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1943, to Oct. 8 1943, and that I last saw him alive on 19

Immediate cause of death

Pneumonia

Duration

4 days

Due to Cerebral Hemorrhage and Paralysis

5-6

days

Due to Hypertension & Arterio-sclerosis

2 years

Other Conditions Sensitivity and Arrhythmia fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Mungatone Jr.

Address 332 E. University Ave. Date signed 10/14/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08973

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Lehigh St

(c) Hospital or institution:

South Baltimore Genl Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Mary Stachowski

3 (b) If veteran, name was

3 (c) Social Security Account

No. 2nd

4. Sex

FEM

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Martin

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

Mar 7 1886

8. AGE:

Years

Months

Days

If less than one day

57

67

1

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Own Home

12. Name

Michael Zablowski

13. Birthplace

Germany

14. Maiden Name

Anna Petza

15. Birthplace

Germany

16 (a) Informant

Mrs Martin Stachowski

(b) Address

811 S. Ross St.

17 (a) Burial

(b) Date thereof

Oct 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Stanislaus C

Location

Baltimore City

18 (a) Funeral director

John M. Weber

(b) Address

408 S. Chester St

19 (a) Date of registration

Oct 11 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

811 S. Ross St.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 8 1943 at 4:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943, to Oct 8 1943, and that I last saw her alive on Oct 8 1943.

Immediate cause of death

Carcinoma of hepatic flexure of colon

Due to

Bronchopneumonia

Duration

Oct 5/43

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy

None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

None

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Esther M. K.

Address

842 S. E. Ave Date signed 10-8-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 08974

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2242 Fleet St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Magdalen Prosybyl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1859

8. AGE:

Years

Months

Days

If less than one day

84

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

John Prosybyl

13. Birthplace

Poland

MOTHER

14. Maiden Name

unknown

15. Birthplace

Poland

16 (a) Informant

Miss Cecilia Prosybyl

(b) Address

2242 Fleet St

17 (a)

Burial

(b) Date thereof

Oct 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Rosary Church

Location

Baltimore County

18 (a) Funeral director

John M. Weber

(b) Address

40 P S. Chester St

19 (a)

OCT 11 1943

VS 100

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2242 Fleet St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 8

1943, at 5:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1943 to Oct 8 1943.

and that I last saw him alive on Oct 8 1943.

Immediate cause of death

Coronary Occlusion

10/7/43

Due to

Chr. Myocardial v

1940

Due to

Arterio Sclerosis

1933

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William Prosybyl

Address

801 W. Lombard St

Date signed

Oct 9/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

8975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

08975

T. N

71741

Registered No.

13B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 months

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1517 Lancaster St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward Iezkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 10th 1923

8. AGE: Years 20 Months 1 Days 0 29 hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

12. Name Walter Iezkowski

13. Birthplace Poland

14. Maiden Name Alice Rybacks

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Oct 13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cemetery
Location Baltimore County

18 (a) Funeral director Mrs. Mary Weber

(b) Address 401 S - Chester St

19 (a) OCT 11 1943

VS 120

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-43 19 at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1942 to 10-9 1943, and that I last saw him alive on 10-10 1943.

Immediate cause of death

Renal TB

Duration

7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mott

Address 204

Date signed 10/10/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08976
438811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08976
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHN HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JAMES LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

BLACK

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

PEARL

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

45

Months

Days

If less than one day

hr.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

FARMER

11. Industry or business

MOTHER FATHER

12. Name

JAMES LEE

13. Birthplace

VA.

14. Maiden Name

CHARLOTTE WILMER

15. Birthplace

MD

16 (a) Informant

RECORDS

(b) Address

JOHN HOPKINS HOSPITAL

17 (a)

Burial

(b)

Date thereof Oct 13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rich. Wash. Cem.

Location

Yon. Church Hill Mt.

18 (a) Funeral director

Edgar & Lane

(b) Address

Church Hill Mt.

19 (a)

Date rec'd by registrar

10-11-43

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County QUEEN ANNE

(c) City or town

CHURCH HILL

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1943 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1943 to Oct 10 1943, and that I last saw him alive on Oct 10 1943.

Immediate cause of death

nephrosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John R. Birmingham

Address

J. H. H.

Date signed

10-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08977

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga Sts*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *J. Carne.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Highlandtown, Md.*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *620 Wilson Ave*
(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3. (a) FULL NAME

John Giovanni Pedrolini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife *Mary Pedrolini*

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) *April 27, 1877*

8. AGE: Years Months Days

66

5

14

13

hr.

min.

9. Birthplace

Italy

(town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name *James Pedrolini*

13. Birthplace *Italy*

14. Maiden Name *Johanna Bossari*

15. Birthplace *Italy*

16 (a) Informant *Mary Pedrolini*

(b) Address *620 Wilson Ave, Highlandtown*

17 (a) *Burial* (b) Date thereof *10-12-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Sacred Heart*

Location *Balti. Md.*

18 (a) Funeral director *John C. Kelly Inc*

(b) Address *2435 E. Oliver*

19 (a) *11 1943*

(b)

Registrar

Registrar

VS 134

Christington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 19, 1943* at *4¹⁵ PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 1, 1943* to *Oct 19, 1943*, and that I last saw him alive on *Oct 10, 1943*.

Immediate cause of death

Uremia

Due to

Portal Cirrhosis

Due to

Other Conditions *C-V Disease*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury

23. Signature *Robert B. Timney*

M. D.

Address *Mercy Hosp* Date signed *10/19/43*

08978

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 08978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610)

2-FULL NAME Baby I. Leage

(a) Residence No. 114

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 10/10/43

7-AGE.

If LESS than 1 day.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country).

10-NAME OF FATHER Herman J. Leage

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER Mary Kate Leage

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-

(Informant)

(Address)

OCT 11 1943

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from 10/10/43 to 10/10/43

that I last saw h. / w. alive on 10/10/43

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) Breech Birth & Asphyxia

18-Where was disease contracted? If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Greenberg

(Address) 462 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 08979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08979

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

709 W North Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

18 yrs.

3 (a) FULL NAME

Caroline Tooma

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-07-8737

4. Sex

Female

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Henry Tooma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 2-1911

8. AGE:

Years

Months

Days

If less than one day

32

1

7

hr.

min.

9. Birthplace

Johnstown Pa.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Writers

FATHER

12. Name

Joseph Surigio

13. Birthplace

Italy

14. Maiden Name

Mary Jaffer

15. Birthplace

Penn.

16 (a) Informant

Mrs. Little

(b) Address

1710 N. Wakewood Ave

17 (a)

Buried

(b) Date thereof

10/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mount Pleasant

Location

Baltimore

18 (a) Funeral director

Philip Hervey Jones

(b) Address

2024 Orleans St.

(a) 11 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

709 W. North Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 9

1943, at

3:55 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Intra-Cerebral Hemorrhage
Due to Subarachnoid Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Thomas J. Mulcahy

M.D.

Date signed

10/10/43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08980
442590

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08980
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Beverly Rae Wainwright

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-4-41

8. AGE:

Years

2

Months

5

Days

7

If less than one day

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Walter Wainwright

13. Birthplace

Md.

14. Maiden Name

Elliott (Anna)

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Funeral

(Burial, cremation, or removal)

(b) Date thereof

10 11 43

(month) (day) (year)

(c) Cemetery or crematorium

Location

Deplin Md.

18 (a) Funeral director

Philip Herwig Sons

(b) Address

2824 Orleans St.

19 (a)

Johnston Williams M.D.

OCT 11 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Worcester

(c) City or town

Ocean City

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7 Philadelphia Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-11

1943, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1943, to Oct 10 1943, and that I last saw her alive on Oct 11 1943.

Immediate cause of death

Tuberculosis

Meningitis

Duration

8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John G. Gault

Address

Johnston Williams M.D.

Signed 10/11/43

G 08981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08981
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof 10/12/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

Street No.

(e) Citizen of foreign country

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10/8 1943 to 10/8 1943

and that I last saw him alive on 10/8 1943

Immediate cause of death

Coronary

Occlusion.

Due to

Arterio-

sclerotic heart

Due to

Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

placed

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

12 hrs

0 yrs

5 yrs

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

08982

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1018 E. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

3 (a) FULL NAME

John Davis

3 (b) If veteran, name war

3 (c) Social Security Account

No. ?

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

1896

8. AGE: Years Months Days

If less than one day

47

hr

min.

9. Birthplace

Not Known

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Not Known

13. Birthplace

" "

14. Maiden Name

Not Known

15. Birthplace

" "

16 (a) Informant

Rosie Ribero

(b) Address 1018 E. Pratt St.

17 (a) Burial

(b) Date thereof

10/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

Elroy C. Wilson

(b) Address

1000 Brantley Ave.

19 (a) 12/1/42

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1018 E. Pratt St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 9 1943 at 5:30 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from Oct. 7 1943 to Oct. 9 1943.

and that I last saw him alive on Oct. 9 1943

Immediate cause of death Central atherosclerosis

Due to Hypertension

Due to Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Mary J. Seery

Address 200 E. Pratt St.

Date signed 10/11/43

PHYSICIAN

Underline the cause to which death should be charged statistically

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Rouzer G 08983
119a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1010 S. Eutaw St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/9 1942 at 10:04 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1942 to 10/9 1942, and that I last saw him alive on 10/9 1942.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08984

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08984
Registered No.

84221 YA

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **4940 Eastern Avenue**
- (c) Hospital or institution:
BALTIMORE CITY HOSPITALS
- (d) Length of stay in hospital or inst. (yrs., mos., or days) **1 day**
- (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

3 (a) FULL NAME

Daniel G. Mack

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored6 (a) Single, married, widowed, or
divorced. **Married**6 (b) Name of husband or wife **Beatrice Mack**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **April 8, 1874**8. AGE: Years Months Days If less than one day
69 **6** **1** hr min.9. Birthplace **Maryland**

(Town, county, and state)

10. Usual Occupation

Pastor of Baptist Church

11. Industry or business

12. Name **Thomas Mack**13. Birthplace **Maryland**14. Maiden Name **?**15. Birthplace **Maryland**16 (a) Informant **BALTIMORE CITY HOSPITALS**(b) Address **(RECORDS)**17 (a) **Burial** (b) Date thereof **10/13/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Arbutus Mem. Park**
Location18 (a) Funeral director **Elroy C. Wilson**(b) Address **1000 Brantley Ave.**19 (a) **10/14/43** (b)
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
- (c) City or town **Balto.**
(If outside city or town limits, write RURAL and give town)
- (d) Street No. **2133 Druid Hill Avenue**
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 9** 19**43** at **2:00 PM**21. I certify that death occurred on the date above stated; that I attend-
ed deceased from **Oct. 7** 19**43**, to **Oct. 9** 19**43**,
and that I last saw him alive on **Oct. 8** 19**43**.

Immediate cause of death

Broncho pneumonia

Duration

2 days

Due to

Acute Pneumonia, Hypertension, and Uremia

Due to

1 day

Other Conditions

Hypertension, C.K.D.**??**

(Include pregnancy within 3 months of death)

Date of operation **marked BPH**Major findings of operation: **Hemorrhage, Cystitis, moderate Pyelitis, and of autopsy: early pneumonia**

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **D. J. Bingham**Address **Balto. City Hall** Date signed **10/3/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08985
Registered No.1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Charles G.

Hutchinson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

79

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

10/11/43
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 11 1943

VS 151

2. USUAL RESIDENCE OF DECEASED:

(a) State U. C. (b) County

(c) City or town

Wilkeson

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11

1943, at 10 AM

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma

of bladder with metastases

Due to:

Other Conditions Marked by hypertrophy of

bladder

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Robert L. Graham M.D.

Medical Examiner.

Date signed

Oct. 11 1943

08986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08986
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1010 Hatch Court

(c) Hospital or institution:

Brooklyn Balto. Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Brooklyn Balto. Md
(If outside city or town limits, write RURAL and give town)

(d) Street No.

1010 Hatch Court

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Joe Barker

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

19 hr. A

min.

9. Birthplace

Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Elmer F. Barker

13. Birthplace

Hot Springs N.C.

MOTHER

14. Maiden Name

Florence Craddock

15. Birthplace

Columbia N.C.

16 (a) Informant

Mr Elmer F. Barker

(b) Address

1010 Hatch Court

17 (a)

Burial

(b) Date thereof

Oct 12-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill Cem.

Location

Brooklyn, Balto. Md

18 (a) Funeral director

Matton Schilling

(b) Address

3914 S. Hanover St

19 (a)

(b)

(Date and Registrar)

Huntington Hillman

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 10, 1943, 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9, 1943, to Oct 10, 1943, and that I last saw him alive on Oct 10, 1943.

Immediate cause of death

Cerebral hemorrhage

Duration

Due to

Prolonged difficult

Due to

first stage of labor

Rigid torso.

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

R. A. Barker

Address

4710 P. Avenue

Date signed

10/11/43

CT 1-1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08987

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08987

Registered No.

61

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 639 N. Fulton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 639 N. Fulton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Walter Jefferson

3 (b) If veteran, name was

3 (c) Social Security Account

No 245-16-7533

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Amelia Jefferson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1884

8. AGE: Years

59

Months

4

Days

2

If less than one day

hr.

min.

9. Birthplace

Balt. Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Postal Clerk

FATHER
MOTHER

12. Name Clayton Jefferson

13. Birthplace Md.

14. Maiden Name Clara Hanson

15. Birthplace Md.

16 (a) Informant Mrs Amelia Jefferson

(b) Address 639 N. Fulton Ave

17 (a) Burial (b) Date thereof 10/14/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balt. Co. Md.

18 (a) Funeral director William Cook Inc

OCT 12 1943 St. Paul St.

(Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11th 1943 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Oct 11 1943, and that I last saw him alive on Oct 11 1943.

Immediate cause of death Brain Hemorrhage

Duration

One week

Due to Diabetes Complicated with coma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thos. H. Phillips M. D.

Address 1939 Edmond St Date signed Oct 11/43

G 08988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08988

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Bertha Ziegfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Aug 5 - 1866

8. AGE: Years Months Days

77

2

6

If less than one day

hr.

min.

9. Birthplace

Rochester N.Y.

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

Butler Bros.

FATHER

12. Name

Julius Ziegfeld

13. Birthplace

Germany

MOTHER

14. Maiden Name

Margaret Sephardt

15. Birthplace

Germany

16 (a) Informant

Oliver C. Ziegfeld

(b) Address

2914 Glenmore Ave.

17 (a)

Burial

(b) Date thereof

10/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. Paul St.

(Date rec'd by registrar)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2914 Glenmore Ave.

(If rural give location)

(e) Citizen of foreign country

American

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/43 19 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1943, to 10/11 1943, and that I last saw him alive on 10/10/43 19.

Immediate cause of death

Indurated anemia

Due to Cachexia

Due to

Ca of rectum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. Raynor

Address

Md. General Hosp.

Date signed 10/11/43

M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08989

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

334 + Calvert St

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

12 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2309 Maryland Ave

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert J. Costley

The Costley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 28-1878

8. AGE:

Years

Months

Days

If less than one day

65

3

12

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Robert J. Mc Costley

13. Birthplace

Ireland

14. Maiden Name

Mary A. Ferry

15. Birthplace

Baltimore Md

16 (a) Informant

Theresa Wiseman

(b) Address

2309 Greenmount Ave

17 (a)

Burial

(b) Date thereof

Oct 13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Holy Cross Church Rd

Location

Harford Road

18 (a) Funeral director

William Cook Inc

(b) Address

1847 St Paul St

OCT 12 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 10

1943, at 11 A.M.

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fracture of

skull, fracture of pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

October 9th 1943 9³⁰ M.

(b) Where did injury occur?

Charles St near 27th St.

(c) Did injury occur at home, on farm, industrial place, in public

place? street

While at work? No

(d) Means of injury

Struck by auto

23. Signature

Robert L. Graham

M.D.

Date signed

October 10 1943.

G 08990

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 11, 1943, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 31, 1943 to Oct 11, 1943 and that I last saw him alive on Oct. 11, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

Include pregnancy within 3 months of death

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 12 1943

HENRY MURNELL

G 08991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08991

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1439 E. Fayette St.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Lelma Wooden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1900

8. AGE:

Years

Months

Days

If less than one day

43

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Realie Perry

13. Birthplace

N. C.

14. Maiden Name

Royanna Harris

15. Birthplace

N. C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Shipped

(Burial, cremation, or removal)

(b) Date thereof

10 / 13 / 43

(c) Cemetery or crematory

Perry Chapel

Location

North Baltimore

18 (a) Funeral director

Mrs Ida Bailey

(b) Address

1421 Jefferson St

19 (a)

(Date rec'd by registrar)

(b) Registrar

William M. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-101943, at 8:15 M21. I certify that death occurred on the date above stated; that I attended deceased from Oct-10 1943, to Oct-10 1943, and that I last saw him alive on Oct-10 1943.

Immediate cause of death

Subarachnoid Hemorrhage

Due to

Hypertension and CNS syphilis

Due to

Mrs. J. Bailey

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Abraham GeneAddress Johns Hopkins Hospital

Date signed

Oct-13

G 08992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08992
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4700 Harford Road
- (c) Hospital or institution:
Snyder Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) Maryland (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 5616 Belle Vista Ave.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME

Mamie L. McDonnal

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jonathan G. McDonal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th, 1880

8. AGE: Years 63 Months 5 Days 5 If less than one day
hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name James Lewis13. Birthplace Baltimore Maryland14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Mr. Jonathan G. McDonnal(b) Address 5616 Belle Vista Ave.

17 (a) Burial (b) Date thereof Oct. 14, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Joseph P. Pomeroy(b) Address 7401 Belair Road

19 (a) 12-1943 (b) 12-1943
vs 114

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10th, 1943 11.30M P.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2, 1943 to Oct 10, 1943, and that I last saw her alive on Oct 10, 1943.

Immediate cause of death

Apoplexy (Cerebral Hemorrhage)

Duration

1 week

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph PomeroyAddress 2200 E. Madison Date signed 10/12/43 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN THESE SPACES RESERVED FOR BINDING

THE MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

G 08993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08993
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2-1943

rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 11 1943 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

Oct 9 1943 to Oct 11 1943

and that I last saw her alive on Oct 11 1943.

Immediate cause of death

Distress of newborn

Due to

Due to

Other Conditions

Inter cranial hemorrhage.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Univ. Hosp.

Date signed 10/11/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 08994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08994
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Levindale Home for the Aged

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Greensprings & Rogers

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

Harry Miller

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 1880

8. AGE:

Years

Months

Days

If less than one day

63

4

hr.

min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual Occupation

Oxderly

11. Industry or business

Levindale Old Age Home

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Levindale Old Age Home

(b) Address

Belvedere Ave & Greensprings Ave

17 (a)

Burial

(b) Date thereof

Oct 12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Chet Shalomore

Location

Odyssey St.

18 (a) Funeral director

Sol L. Linsin & Bros

(b) Address

1126 W. North Ave

19 (a)

OCT 12 1943

(b)

Washington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1943 at 8:30 AM21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

Means of injury

23. Signature

Robert Lee Pralson

M.D.

Date signed

Oct. 11 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 08995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 08995

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 Wicklow Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Wicklow Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
CHARLES FRANKLIN GODWIN

3 (b) If veteran, name war none **3 (c) Social Security Account** No. no

4. Sex male **5. Color or race** white **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife. Lucia **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1873

8. AGE: Years 69 Months 11 Days 1 **If less than one day** hr. min.

9. Birthplace Barclay, Md.
(Town, county, and state)

10. Usual Occupation Grocer - retired

11. Industry or business

12. Name Godwin

13. Birthplace Md.

14. Maiden Name Martha Nickerson

15. Birthplace Md.

16 (a) Informant Mrs. Lucia Godwin

(b) Address 626 Wicklow Rd.

17 (a) Burial (b) Date thereof 10/13/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

12 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1943 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 1943, and that I last saw him alive on Oct 1943.

Immediate cause of death Coronary Thrombosis

Due to Coronary Thrombosis

Due to Myocardial Infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry F. Horner

Address 401 E. Howard St. **Date signed** 10/14/43

Duration

10 min.

Due to

Coronary Thrombosis

Due to

Myocardial Infarction

PHYSICIAN

Underline the

cause to which

death should be

charged statistically.

G 08996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

* G 08996

Registered No. 10/206

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

Caton + Wilkens

(c) Hospital or institution:

ST. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Jacksonville, Fla.
(If outside city or town limits, write RURAL and give town)

(d) Street No.

139 W. Ashley St.
(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Marie Finkelstein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. widow

6 (b) Name of husband or wife

Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1880

8. AGE: Years

63

Months

5

Days

24

If less than one day

hr.

min.

9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name John Smith

13. Birthplace Russia

14. Maiden Name Ida -

15. Birthplace Russia

16 (a) Informant Dr. Harold Finkelstein

(b) Address 1023 N. Calvert St.

17 (a) Removal

(b) Date thereof

10/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Evergreen Cem.

Location

Jacksonville, Fla.

18 (a) Funeral director

W. J. Tucker & Son

(b) Address

Baltimore, Md.

(Date rec'd by registrar)

H. J. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 12 1943 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from 8-15 1943 to 10-12 1943
and that I last saw her alive on 10-12 1943

Immediate cause of death

Myocardial failure
and Coronary Occlusion

Due to

Hypertensive - cardiac -
valvular renal disease

Other Conditions

Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. J. Tucker & Son

M. D.

Address

St. Agnes Hosp.

Date signed

10-12-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

VB 184

10/12/43

04451/2

G 08997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08997
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 7/16 1943, to 10/12 1943,

and that I last saw him alive on 10/11/43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

OCT 12 1943

G 08998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 08998
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 610 S. Ellwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days
79 4 28 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Underlying cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

10-8-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

REMOVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 12 1943

VS 126

Funeral Home

G 08999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 08999

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1212 Light St.*

(c) Hospital or institution:

South Baltimore Gen'l Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 d.*(e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Balto.*

(If outside city or town limits, write RURAL and give location)

(d) Street No. *1000 Hollins St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Ronald James LOWE.

3 (b) If veteran, name war

✓

3 (c) Social Security Account

No. *✓*

4. Sex

m

5. Color or race

W.

6 (a) Single, married, widowed, or

divorced. *S.*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 8, 1942*

8. AGE: Years Months Days If less than one day

*17. - 4 hr. min.*9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Allyn Lowe*13. Birthplace *Balto. Md.*14. Maiden Name *Arlia Harmon*15. Birthplace *Balto. Md.*16 (a) Informant *Mr. Allyn Lowe*(b) Address *1000 Hollins St.*17 (a) *Burial* (b) Date thereof *Oct. 13/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Cedar Hill*Location *Annapolis, Md.*18 (a) Funeral director *Frederick H. Hancock & Son*(b) Address *1216 D. Charles St.*

19 (a) (b)

Registrar

Date received *Oct 12 1943*

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 12 1943* at *6:20 A.M.*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *Oct. 8 1943* to *Oct. 12 1943*.and that I last saw him alive on *Oct 12 1943*.

Immediate cause of death

*Acute gastro enteritis*Due to *Marasmus.*

Due to

Other Conditions *Bilab acute**pernicious anemia*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Theodore J. Maziane*Address *Sol Nat to Gen Hosp* Date signed *10/12/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 12 1943

G 09000

MJ- 83428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09000

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo., 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1913 W. Saratoga St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Nile DiPaule

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Anthony (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1894

8. AGE: Years 49 Months 8 Days 23 If less than one day hr. min.

9. Birthplace Italy

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name Salvatore Miceli (D)

13. Birthplace Italy

14. Maiden Name Antionetta Pazzo

15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10/12/43 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem

Location Old Frederick Rd.

18 (a) Funeral director J. J. Taylor & Sons

(b) Address 1318 Light St.

19 (a) Date of registration OCT 12 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1943 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1943 to 10-10 1943, and that I last saw him alive on 10-10 1943

Immediate cause of death

Pneumonia

Carcinoma of Colon

Due to

Coronary Occlusion

Due to

Cardiac Insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-29-43

Major findings of operation Carcinoma

of Colon

or autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald B. Nett

Address Falls City Hosp Date signed 10-12-43

Duration

1 day

?

?

?

?

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09001

20
1943
YA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09001

Registered No.

81898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

3 (a) FULL NAME

Pearl Turner

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife. William (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1902

8. AGE: Years Months Days If less than one day
41 8 16 hr. min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name John Bonner

13. Birthplace North Carolina

14. Maiden Name Bessie Farmer

15. Birthplace North Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Oct 13, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Schroeder St

(Date filed by Registrar)

VB 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 515 N. Carey Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1943, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 6-7 1942 to 10-8 1943.
and that I last saw her alive on 10-8 1943

Immediate cause of death

Pulmonary Tbc

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Matt

Address

Ore

Date signed 10/9/43

50

VR 150

The
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09003

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1117 N. Gilmore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

3 (a) FULL NAME

Emma Stansberry

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Robert Stansberry

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

Feb 7 1909

8. AGE:

Years

Months

Days

If less than one day

4

8

1

hr.

min.

9. Birthplace

Harford Co. Md.

10. Usual Occupation

none

11. Industry or business

none

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c)

(d) Date rec'd by registrar

(e) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1948

43

5

PM

21. I certify that death occurred on the date above stated; that I attended

deceased from

and that I last saw her alive on

Immediate cause of death

Broncho Pneumonia

Due to

Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place)

(e) Means of injury

23. Signature

J. T. Lunn

Address

523 N. Arlington St.

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

OCT 12 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09004

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3130 Crestman St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Deborah Ann Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

Unless less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 11

1943, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Oct 11 1943, and that I last saw him alive on Oct 10 1943.

Immediate cause of death

Myocardial degeneration

Due to

Arteriosclerosis

Due to

Chr. nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Wm. L. Todd

Address

735 N. Fulton

Date signed

10/11/43

G 09005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09005

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1800 N. Milton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1800 N Milton Ave

(If rural, give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frank E. Green

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Lopha Green6 (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) Oct 25 1892

8. AGE:

Years

Months

Days

If less than one day

50111615

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

Pipe Fitter

11. Industry or business

Gas & Electric Co

FATHER

12. Name

Green Green

13. Birthplace

Balto Md

MOTHER

14. Maiden Name

Daphne Dock

15. Birthplace

Balto Md

16 (a) Informant

Lopha Green

(b) Address

1800 N Milton

17 (a)

Burial

(b) Date thereof

10/13/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hof Redemptor

Location

Belgian Rd. Balto.

18 (a) Funeral director

3000 E. 1st St. Moran

(b) Address

3000 E. 1st St. Moran

19 (a)

(Name and address of registrar)

Huntington Hillman, 1000

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 10 1943 at 7:30 am21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1943 to Oct 10 1943, and that I last saw him alive on Oct 9 1943.

Immediate cause of death

Cerebral HemorrhageDue to arterio sclerosisDue to hypertensionDue to Chronic Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. S. StevensAddress 2878 Harford Rd

Date signed

10/11/43

OCT 12 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09006
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2809 Huntingdon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Ella Snouffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Wm. W. Snouffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 15, 1870

8. AGE:

Years

73

Months

7

Days

26

If less than one day

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Corrine Rene

(b) Address

1008 W 36th St

17 (a)

Burial

(b) Date thereof

Oct 14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Marys

Location

Hampden

18 (a) Funeral director

Chenoweth & Donovan

(b) Address

3615-17 Chestnut Ave

19 (a)

(b)

(Date rec'd by registrar)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2809 Huntingdon Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 11, 1943 at 2 P. M

21. I certify that death occurred on the day above stated that I attended deceased from Oct 10 1943 to Oct 11 1943 and that I last saw him alive on Oct 11 1943

Immediate cause of death

Chronic Myocarditis

Due to

Other Conditions

Arteriosclerosis index
Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at — M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify if possible)

(e) Means of injury

23. Signature

Dr. Frank J. ...

Address 112 W. 25th Date Oct 12, 43

OCT 12 1943

G 09007

439269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09007

Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MOS.

(e) Length of stay in Baltimore (yrs., mos., or days) 9 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~MD~~ (b) County balto.(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 610 S. Chapel St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edgar Stichel

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 217 09 4940

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Martha Stichel6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

8/31/1900

8. AGE:

Years

Months

Days

If less than one day

43110

hr.

min.

9. Birthplace

va.

(Town, county, and state)

10. Usual Occupation

Printer Helper

11. Industry or business

Spanous Point and12. Name ROBERT Stichel

13. Birthplace

va.

14. Maiden Name

Margaret Stichel

15. Birthplace

va.

16 (a) Informant

(b) Address

Records

JOHNS HOPKINS HOSPITAL

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 13/43

(month) (day) (year)

(c) Cemetery or crematory MORELAND MEMORIAL

Location

TAYLOR AVE.

18 (a) Funeral director

Lilly and Geiler INC.

(b) Address

403 S. ROLFE ST.

(Date rec'd by registrar)

Oct 12 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 - 1943 at 1210 M21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1943 to Oct 10 1943, and that I last saw him alive on Oct 10 1943.

Immediate cause of death

arteriosclerotic heart disease - mural thrombi + multiple infarcts

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 10-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09008

Registered No.

MJ- 84105

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 35 S. Ann Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Thomas Harrigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 17, 1875

8. AGE:

Years 67

Months 9

Days 25

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Michael (D)

13. Birthplace Ireland

14. Maiden Name Julia Hayden

15. Birthplace Ireland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

Baltimore Rd

18 (a) Funeral director M. W. E. D. Apple

(b) Address Home 6010 & Ann Sts.

19 (a) Date rec'd by registrar

(b)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1943 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1943 to 10-12 1943, and that I last saw him alive on 10-12 1943.

Immediate cause of death.

Carcinoma of Mouth

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature Paul Hatt

Address R 214

Date signed 10-12-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09009

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1039 W. Ashburton St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife of the late Margaret L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 12 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/11/43

21. I certify that death occurred on the date above stated; that I attended deceased from 10-43 to 10-11-43

and that I last saw him alive on 10-7-43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09010
Registered No.

83692 YA

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Mahala Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1884

8. AGE: Years 58 Months 9 Days 27 1/2 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John Petterson

13. Birthplace Baltimore, Maryland

14. Maiden Name Mary Pirie

15. Birthplace Baltimore, Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10-12-43 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park, Baltimore, Md.

18 (a) Funeral director Charles E. Cooper

(b) Address 512 N. Carrollton Ave.

12 1943

(b) by registrar
Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 512 N. Carrollton Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1943, at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1942, to 10-6 1943, and that I last saw him alive on 10-8 1943.

Immediate cause of death

Pulmonary TBC

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: 2 above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Hart

Address Balto

M. D. Date signed 10-9-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09011

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) B-

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

(m) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 09012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09012
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1832 Rensay St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1832 Rensay St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account
No. 705-05-7801

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mary E. Condit

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

Sept 15, 1874

8. AGE:

Years

Months

Days

If less than one day

64

24

hr.

min.

9. Birthplace

Mary Co. Md
(Town, county, and state)

10. Usual Occupation

Retired Clerk

11. Industry or business

Railroad

FATHER

12. Name

John E. Greenfield

MOTHER

13. Birthplace

Mary Co. Md

14. Maiden Name

Elizabeth Patton

15. Birthplace

Mary Co. Md

16 (a) Informant

James M. Greenfield

(b) Address

1832 Rensay St

17 (a) Burial

(b) Date thereof

10/13/43
(month, day, year)

(c) Cemetery or crematory

London Park

Location

Frederick Ave

18 (a) Funeral director

H. J. Williams

(b) Address

1601 Hollins St

19 OCT 13 1943

H. J. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1943 at 11⁵⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943 to Oct 9 1943. and that I last saw him alive on Oct 8 1943.

Immediate cause of death

Hypertensive Cardiovascular Disease

Duration

3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert Korman

Address 1934 Wilkes Ave Date signed 10/12/43

M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09013
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Gen Hospital 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos 5

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Anne Arundel

(c) City or town Brooklyn Route 9
(If outside city or town limits, write RURAL and give town)(d) Street No. Box 98 Balto. 24.
(If rural give location)(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3 (a) FULL NAME

William E Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1943

8. AGE: Years Months Days less than one day

5

10

11

hr.

min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Wm H Scott

13. Birthplace Coalton W. Va.

14. Maiden Name Cleo V Halmick

15. Birthplace W Va

16 (a) Informant Wm William H Scott

(b) Address 201 Potomac (Brooklyn Md)

17 (a) Removal (b) Date thereof 10/12/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arnold Hill Cem
Location Elkins W Va

18 (a) Funeral director William M Marek

(b) Address 715 Light St.

19 (a) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1943 at 3:04 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1943 to Oct 12 1943 and that I last saw him alive on Oct 11 1943.

Immediate cause of death

Respiratory failure

Due to Marasmus

Due to Acute gastric enteritis

11. 1. Bilal suppuration of ribs

Other Conditions malice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theodore J. Magiano M.D.

Address So Baltimore Gen Hosp Date signed 10/12/43

Duration

8 hours 15 min.

3 days

2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in pencil. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X V
937

G 09014
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Ave.
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D (b) County
(c) City or town Washington D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2138 California St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Roache
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-1860
8. AGE: Years Months Days If less than one day
83 4 14 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Thos. Edw. Doyle
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary
15. Birthplace Ireland

16 (a) Informant Elise Roache
(b) Address 2138 California St. Wash. D.C.

17 (a) Removal (b) Date thereof 10/13/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Washington, D.C.

18 (a) Funeral director W. T. Tucker & Sons
(b) Address Baltimore Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1943 M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 10/11 1943.

Immediate cause of death Arteriosclerotic C-v-D

Due to
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Arthur Roache

Address St Agnes Hosp Date signed 10/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 12 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09015

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JAMES MADYNE HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va.(b) County Fairfax(c) City or town Vienna

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Wilbur Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Beulah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-6-00

8. AGE:

Years

Months

Days

If less than one day

4356

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

FATHER

12. Name

Joseph M Bowman

13. Birthplace

Va

MOTHER

14. Maiden Name

Annie Miller

15. Birthplace

Va

16 (a) Informant

Records

(b) Address

JOHN BURNED HOSPITAL17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

OCT 12-43

(month) (day) (year)

(c) Cemetery or crematory

Location Sumner Va. F. & H. Co.

18 (a) Funeral director

Wm. H. H. Co.

(b) Address

Wm. H. H. Co. 1600 Hilly

19

OCT 12 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct-12-

1943

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1943, to Oct 12 1943,and that I last saw him alive on Oct-12 1943.

Immediate cause of death

Increased intracranial pressureDue to 2 Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-10-43Major findings of operations: Increased pressureof autopsy: Not done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. H. H.

Address

J. H. H.

Date signed

M. D.

10/12/43

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09016

Registered No. 34

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address Church Home & Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs

3 (a) FULL NAME

Sarah Jane Lonscott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 2, 1943

8. AGE: Years Months Days If less than one day
5 hr. 29 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Ralph Henderson Lonscott

13. Birthplace Salisbury N.C.

14. Maiden Name Beagle Sedona Lonscott

15. Birthplace Maryland

16 (a) Informant Mrs. Beagle Lonscott

(b) Address 2446 Beagle Rd. Baltimore

17 (a) Burial (b) Date thereof 10/13/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glenox

Location St. Michael's Md.

18 (a) Funeral director Daniel Harrison

(b) Address St. Michael's Md.

19 (a) OCT 12 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2446 Beagle Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1943 at 1:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1943, to Oct 12 1943, and that I last saw her alive on Oct 12 1943.

Immediate cause of death

Stillborn neonatorum

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabelle Harrison

M. D.

Date signed 10/13/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 09017
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days) 4

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town.)

(d) Street No. 22 Bank St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

EDWARD WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1894

8. AGE:

49

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location: UNIVERSITY MEDICAL SCHOOL OCT 11 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19

OCT 13 1943

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1943 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Abscess, right lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature R. J. Wallenwatsen M.D.

Date signed 10-6-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 94a G 09018

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 947 W. Baltimore St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROBERT BENSON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-9-7

8. AGE:

Years

Months

Days

If less than one day

46

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 11 1943

18 (a) Funeral director

(b) Address

19 (a) 13 1943

(Date rec'd by registrar)

Commissioner of Health

Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1943 at 10am

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cervical occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wollenmeyer M.D.

Date signed 8-14-43

0430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09019
Registered No.

1. CAUSE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME *William Cornell*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE:

Years

Months

Days

If less than one day

75

hr.

min.

9. Birthplace

?

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL OCT 11 1943*

18 (a) Funeral director

Commissioner of Health

(b) Address

19

OCT 13 1943
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

Barrett

(c) City or town

Kitzmiller

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-3-

1943, at *7:20 P.M.*

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

Fractured ribs, Hemothorax,

Fractured femur.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *10-2-43*, at *8:40 P.M.*

(b) Where did injury occur? *Frederick Ave. & Brunswick St.*

(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *No*

(d) Means of injury *Pedestrian, struck by automobile*

23. Signature *Howard J. Lueders* M.D.

Medical Examiner.

Date signed *10-4-43*

0431

09020

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09020
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County

(c) City or town Brooklyn

(If outside city or town, write RURAL and give town)

(d) Street No. 207

Carroll St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

Svve

Olsen

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

48

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

Commissioner of Health

(b) Address

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 25

1943, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Sept. 25, 1943

9 PM

(b) Where did injury occur?

Harbor foot of Bond St.

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No

(d) Means of injury

Fall in Harbor

23. Signature

Robert L. Grubbs

M.D.

Date signed

Sept. 26, 1943

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09021

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09021

Registered No. 159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hours

(e) Length of stay in Baltimore (yrs., mos., or days) 16 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 910 Whitelock St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Lichtenstein, Infant Boy

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9/28/43

8. AGE: Years Months Days

0

0

0

If less than one day

16 hr.

5 min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

HAARON LICHTENSTEIN

13. Birthplace

Baltimore, Md

MOTHER

14. Maiden Name

FAY KAUFMAN

15. Birthplace

Russia

16 (a) Informant Mrs. Fay Lichtenstein

(b) Address 910 Whitelock St.

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 11 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 13 1943 Huntington Williams, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1943 at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1943 to 9/29 1943, and that I last saw him alive on 9/29 1943.

Immediate cause of death

Premature Infant
27 weeks.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dr. H. H. Davis
Address University Hospital Date signed 9/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

0433

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09022**

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *University Hospital*
(c) Hospital or institution: *W. V. H. Ida*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 da*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James Ducus

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

♂

5. Color or race

W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

not known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

not known

8. AGE:

Years

Months

Days

If less than one day

64 years

hr.

min.

9. Birthplace

Greece

(Town, county, and state)

10. Usual Occupation

Restaurant Owner

11. Industry or business

FATHER
MOTHER

12. Name

Not known

13. Birthplace

Greece

14. Maiden Name

not known

15. Birthplace

Greece

16 (a) Informant

Thomas Riccas

(b) Address

516 Allegheny Ave. Towson

17 (a)

Burial

(b) Date thereof

10-13-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Baltimore, Md.

18 (a) Funeral director

Francis Reese

(b) Address

Westminster, Md

19 (a)

(b)

(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md* (b) County *Baltimore*
(c) City or town *Towson*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *516 Allegheny Ave* -
(If rural give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 9

1943, at *6:45 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 8* 1943, to *Oct 9* 1943, and that I last saw him alive on *Oct 9* 1943

Immediate cause of death

Respiratory failure

Due to

Coronary thrombosis

Due to

Myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

David Morgan

Address

U. Hospital

Date signed *10/9/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 16 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09023

40205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓
17B

G 09023
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **Viola Laird**

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Single**

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **5-10-18**

8. AGE: Years **25** Months **6** Days **1** If less than one day hr. min.

9. Birthplace **Md**
(Town, county, and state)

10. Usual Occupation **STENOGRAPHER**

11. Industry or business

12. Name **Charles Laird**

13. Birthplace **Md.**

14. Maiden Name **Ethel Daugherty**

15. Birthplace **Md**

16 (a) Informant **Records**
(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **10-14-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Crisfield, Md.**

18 (a) Funeral director **Edward Q. Corington**

(b) Address **21 W. 25th St.**

19 (a) (b) Registrar
(Date rec'd by registrar) (Signature)
Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County **Somerset**
(c) City or town **Crisfield**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **Rt 2**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 11 1943** at **2:10 A**

21. I certify that death occurred on the date above stated; that I attended deceased from **Aug 25 1943** to **Oct 11 1943**, and that I last saw her alive on **Oct 11 1943**.

Immediate cause of death

Respiratory failure

Due to **Miliary Tuberculosis**

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation **Aug 26, 1943**
Major findings of operation **Tuberculosis abscess right hip**
of autopsy:

Duration

6 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **John H. Kenne**

Address **Johns Hopkins Hosp** Date signed **10-11-43**

G 09024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09024
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 124 S. Regester St
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 4
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 124 S. Regester St
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Wiktor Jagelo
 3 (b) If veteran, name war First World War 3 (c) Social Security Account No.
 4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
 6 (b) Name of husband or wife Rose Jagelo 6 (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 1888
 8. AGE: Years 55 Months Days If less than one day hr. min.
 9. Birthplace Poland (Town, county, and state)
 10. Usual Occupation Stevedore
 11. Industry or business
FATHER 12. Name Adam Jagelo
 13. Birthplace Poland
MOTHER 14. Maiden Name Margaret Bruck
 15. Birthplace Poland
 16 (a) Informant Rose Jagelo
 (b) Address 124 S. Regester
 17 (a) Burial (b) Date thereof 10/15/43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Holy Cross
 Location Baltimore
 18 (a) Funeral director Frank W. Ogazowski
 (b) Address 1930 Eastern Ave
 19 OCT 13 1943 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH 10/12/43 at 7:00 M
 21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1943 to Oct 12, 1943, and that I last saw him alive on Oct 12 1943.
 Immediate cause of death Coronary Thrombosis
 Due to
 Due to
 Other Conditions Arteriosclerosis
 (Include pregnancy within 3 months of death)
 Date of operation
 Major findings of operation:
 of autopsy:
 22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
 (e) Means of injury
 23. Signature Dr. L. F. Kumbrow M. D.
 Address 554 Eastern Ave Date signed 10/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09025
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EFFIE CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Mar.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

7/28/1885

8. AGE:

Years

Months

Days

If less than one day

58

7

13

hr.

min.

9. Birthplace

7 mi. Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial
(burial, cremation, or removal)

(b) Date thereof

10/15/43
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 13 1943
(Date)

(b)

Huntington Williams
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Va

(b) County

(c) City or town

Alexandria

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1839 N. Chapel St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 11 1943 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis cardiovascular
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

H. Z. Wallamacher M.D.
Medical Examiner

10-12-43

09026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09026

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert St.

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 18(e) Length of stay in Baltimore (yrs., mos., or days) 18

3 (a) FULL NAME

MRS. RENA M. GRAHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Mr. William J. Graham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1892

8. AGE: Years Months Days If less than one day

4834

hr.

min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual Occupation Teacher - Homemaker

11. Industry or business

12. Name Mr. Cyril H. McClelland13. Birthplace Pennsylvania14. Maiden Name Ellen Bailes15. Birthplace Pennsylvania16 (a) Informant Mr. William J. Graham(b) Address 358 Magnolia St., Pa.17 (a) Burial (b) Date thereof Oct 16 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Sylvan HeightsLocation Union Town Pa.18 (a) Funeral director A. R. Riley Slade(b) Address 907 York Road(c) Oct 13 1943 (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn. (b) County(c) City or town Antietam

(If outside city or town limits, write RURAL and give town)

(d) Street No. 358 Magnolia St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1943 10:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1943 to Oct. 12 1943, and that I last saw her alive on Oct. 12 1943.

Immediate cause of death

Cardio-Respiratory failure

Duration

Due to Cerebral embolus10 minDue to Carcinoma of Sigmoid2 mos?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept. 30 43Major findings of operations: Carcinoma of Sigmoidof autopsy: Carcinoma of sigmoid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Heston, Jr.Address Union Memorial Hospital Date signed 11-12-43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09027

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

20. DATE OF DEATH

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09028

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address **3303 Ailes Ave.**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **24 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **3303 Ailes Ave.**

(If rural give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country

3 (a) FULL NAME

CLARA RUTH CURLOTT

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. **NONE**

4. Sex

F

5. Color or race

W6 (a) Single, married, widowed, or divorced. **Widow**6 (b) Name of husband or wife **William Curlott**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 15, 1880**

8. AGE: Years

83

Months

Days

28

If less than one day

hr.

min.

9. Birthplace **Queen Ann, Maryland**

(Town, county, and state)

10. Usual Occupation **At home**

11. Industry or business

12. Name **John Hall**13. Birthplace **Eastern Shore, Maryland**14. Maiden Name **Melvina Gordon**15. Birthplace **Eastern Shore, Maryland**16 (a) Informant **Mrs. Alice Hodgson**(b) Address **3303 Ailes Ave.**17 (a) **Burial** (b) Date thereof **10/13/43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory **Baltimore Cemetery**Location **Baltimore, Maryland**18 (a) Funeral director **Henry Sander & Sons, Inc.**(b) Address **North Ave. & Broadway**

19 (a) (b)

OCT 13 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 11, 1943, at 7:45 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **November 1, 1942, to October 11, 1943.**and that I last saw her alive on **October 9, 1943.**

Immediate cause of death

Strangulated Left Inguinal HerniaDue to **Left Inguinal Hernia**

Due to

Other Conditions **General Arteriosclerosis**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Albert Orsinger**Address **2025 E North Ave.** Date signed **10-11-43**

Duration

3 days**1 year**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09029

Registered No.

119a

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address
 (c) Hospital or institution: *Univ. Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *17*
 (e) Length of stay in Baltimore (yrs., mos., or days) *6 days*

2. USUAL RESIDENCE OF DECEASED:
 (a) State *MD* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *815 N. Franklin St*
 (If rural give location)
 (e) Citizen of foreign country? *no* (Yes or No)
 If yes, name country

3 (a) FULL NAME *Herbert Carter Wagge*

3 (b) If veteran, name war *no* 3 (c) Social Security Account No. *none*

4. Sex *Male* 5. Color or race *Colored* 6 (a) Single, married, widowed, or divorced *Infant*

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 2, 1943*

8. AGE: Years Months Days If less than one day
3 7 hr. min.

9. Birthplace *Baltimore MD*
 (Town, county, and state)

10. Usual Occupation *Infant*

11. Industry or business

12. Name *Herbert Wagge*

13. Birthplace *S. C.*

14. Maiden Name *Anna Carter*

15. Birthplace *Baltimore MD*

16 (a) Informant *Anna Carter Mother*

(b) Address *815 N. Franklin St*

17 (a) *Burial* (b) Date thereof *10-13-43*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt Auburn*
 Location *Baltimore MD*

18 (a) Funeral director *Charles B. Cooper*

(b) Address *512 N. Carrollton Ave*

Huntington Williams, M.D.

OCT 13 1943 (Date rec'd by Registrar)

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 9 1943* at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/3 1943* to *10/9 1943*, and that I last saw him alive on *10/9 1943*

Immediate cause of death *Daily diet* Duration

Due to *nutritional*
diarrhea

Due to

Other Conditions *malnutrition*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *S. L. French*

Address *Univ. Hosp.* Date signed *10/10/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

09030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09030

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution:

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2507 McCulloch St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 8, 1918

8. AGE: Years Months Days If less than one day

25 24 - 1 hr. min.

9. Birthplace

Norfolk, Va.

10. Usual Occupation

11. Industry or business

Shipyard

12. Name Cornelius J. Meyer

13. Birthplace Rocky Mount, N.C.

14. Maiden Name Lucille Smith

15. Birthplace Norfolk, Va.

16 (a) Informant Mildred C. Meyer

(b) Address 2507 McCulloch St.

17 (a) Burial (b) Date thereof Oct. 13, 1943

(c) Cemetery or crematory

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hall

(b) Address 1631 DuPont Hill

19 (a) 13 1943 (b) Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-43 19 at 2:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26-43 to 10-9-43, and that I last saw him alive on 10-9-43.

Immediate cause of death

Generalized Peritonitis

Due to Perforated Gastric Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-26-43

Major findings of operation Perforated Gastric Ulcer

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles B. McDonald

Address 1213 Light St Date signed 10-9-43

Duration

9 days

6 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09031
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1235 E LAMARLE AV

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)(d) Street No. 1235 E LAMARLE ST
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W6 (b) Name of husband or wife Mary Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 - 18678. AGE: Years Months Days If less than one day
76 7 2 hr. min.9. Birthplace West Virginia
(Town, county, and state)10. Usual Occupation Unemployed

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant William Lee Armstrong Jr.(b) Address 4129 MARY X AVE17 (a) Burial (b) Date thereof 10-15-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood
Location18 (a) Funeral director Edward J. Hines(b) Address 3305 Madison AveDate of death Oct 13 1943 Huntington, Maryland, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11/43 at M21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1943 to 10/12 1943, and that I last saw him alive on 10/11 1943.

Immediate cause of death

Intermittent Cardiac
Vascular Disease

Due to

Due to

Other Conditions

Acute hepatitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address 206 E. Pratt St Date signed 10/15/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09032
Registered No.

1. CAUSE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 145 N. Patterson Pl. Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

City or town Baltimore
(If outside city or town limits, write RURAL and give town)

Street No. 145 N. Patterson Pl. Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

GEORGE

J.

PAULUS

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife

Sophia R. Aier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 27, 1864

8. AGE:

Years

Months

Days

If less than one day

79

140

14

hr.

min.

9. Birthplace

Balto., Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

Retired

FATHER
MOTHER

12. Name

Jacob Paulus

13. Birthplace

Germany

14. Maiden Name

?

15. Birthplace

Germany

16 (a) Informant

Joseph Paulus

(b) Address

145 N. Patterson Pl. Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof 10/14/43
(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

M. W. E. Dyke/Sons

(b) Address

Lombard St. at 8th

19 (a)

OCT 13 1943
(Date rec'd by registrar)

Funerary Home, Inc.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10, 1943, at 5:50 PM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.

Date signed 10-12-43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09033

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09033
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date rec'd by registrar

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 8 1943, and that I last saw him alive on Oct 12 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09034

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1219 Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Mary Alice Harvey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Fe

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 29, 1926

8. AGE:

Years

Months

Days

If less than one day

17

4

11

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Taylor Barnes

13. Birthplace

Charlottesville, Va.

14. Maiden Name

Mary Hunt

15. Birthplace

Castroville, Va.

16 (a) Informant

Mary Harvey

(b) Address

1219 Park Ave

17 (a) Burial

(b) Date thereof

Oct 15, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion Cem

Location

18 (a) Funeral director

Mrs. Katie P. Williams

(b) Address

322 N. Chesapeake St.

19 (a)

(b)

Huntington, Williams, Md.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balto.

(If outside city or town limit, write RURAL and give town)

(d) Street No.

1219 Park Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 10, 1943, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1943, to Oct. 10, 1943, and that I last saw him alive on Oct. 10, 1943.

Immediate cause of death

Pulmonary tuberculosis

Duration

6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ralph W. Reinking

Address

426 N. Calmar St.

Date signed 10/13/43

OCT 13 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

442591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09035
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Walter Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/30/39

8. AGE:

Years

Months

Days

If less than one day

4

1

10

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Walter Lower

13. Birthplace

Md.

14. Maiden Name

Nannie Gray

15. Birthplace

S. C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct 18, 1943

(c) Cemetery or crematory

Mt Auburn Cem

Location

18 (a) Funeral director

(b) Address

19 (a)

Date of death

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 306 Myrtle Ave.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 - 1943, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1943, to Oct 10 1943, and that I last saw him alive on Oct 10 1943.

Immediate cause of death

respiratory failure 15 min

CAUSE UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Johns Hopkins

Signed

10/18/43

OCT 18 1943

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09036
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *0-0-4*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *817 N. Lexington St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Benjamin Jones*
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex *Male* 5. Color or race *Negro* 6 (a) Single, married, widowed, or divorced *Single*
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) *June 1871*
8. AGE: Years *72* Months *4* Days *hr.* min.
9. Birthplace *Wilmington N. C.*
(Town, county, and state)
10. Usual Occupation *None*
11. Industry or business

FATHER
12. Name *Samuel Jones*
13. Birthplace *Wilmington N. C.*
MOTHER
14. Maiden Name *Palace*
15. Birthplace *Wilmington N. C.*
16 (a) Informant *George Jones*
(b) Address *674 W. Fairmount Ave*
17 (a) *Burial* (b) Date thereof *Oct. 14, 1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *W. T. Zion Cem*
Location
18 (a) Funeral director *Mrs. Katie K. Williams*
(b) Address *322 N. Schrodor St*
19 (a) (b) *Huntington Williams*
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-9-1943 at 8 P M*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: ☒ natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *at* M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature *Horace J. Macdonald* M.D.
Date signed *10-10-43* Medical Examiner.

1943
10-13-1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 304 Poppleton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

3 (a) FULL NAME

Luminda Gunthrop

3 (b) If veteran, name was

Social Security Account No.

4 Sex

Female Negro

5 Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Lee Gunthrop6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

June 15, 1887

8. AGE:

Years

Months

Days

If less than one day

563254 hr.

min.

9. Birthplace

Winnabow S.C.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

John Harvey

13. Birthplace

Winnabow S.C.

14. Maiden Name

Richard Harvey

15. Birthplace

Winnabow S.C.

16 (a) Informant

John Young

(b) Address

1211 Washington St.

17 (a)

Burial

(b) Date thereof

Oct 18-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

W. T. Auburn Cem.

Location

18 (a) Funeral director

Mrs. Kate Williams

(b) Address

324 S. Howard St.

19

OCT 13 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

304 Poppleton

(If rural, give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 91943 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from April 15, 1942 to Oct 9, 1943and that I last saw him alive on Oct 9, 1943

Immediate cause of death

Cerebral hemorrhageDue to HypertensionDuration 1 dayDue to HypertensionDuration 2 years

Due to

Other Conditions Myocarditishypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature William H. WattsAddress 5154 Arlington AveDate signed 10/12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09038
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Tanzer + Linden*

(c) Hospital or institution:

Maryland General Hosp(d) Length of stay in hospital or inst. (~~mos.~~, mos., or ~~days~~) *2*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1918 Chelsea Rd.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. *NONE*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*widowed*6 (b) Name of husband or wife *Margaret E. Nichols*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 24, 1881*

8. AGE: Years Months Days If less than one day

*61 11 18 hr. min.*9. Birthplace *Dixie Centre, Pa.*

(Town, county, and state)

10. Usual Occupation *retired*

11. Industry or business

12. Name *Nosca Nichols*13. Birthplace *New York*14. Maiden Name *Zaidee Mason*15. Birthplace *New York*16 (a) Informant *Mr. David Nichols*(b) Address *1918 Chelsea Rd.*17 (a) *Burial* (b) Date thereof *10/15/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Druid Ridge Cem.*Location *Pikesville, Md.*18 (a) Funeral director *WM. J. TICKNER & SONS*(b) Address *North & Pa. Aves., Balto. Md.*19 (a) *OCT 13 1943*
(Date rec'd by registrar) *William Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 12 1943* *5:15* *P*21. I certify that death occurred on the date above stated; that I attended deceased from *8-6-43* 19 to *10-12 1943*, and that I last saw him alive on 19

Immediate cause of death

Paralysis Agitans
Due to

Due to

Other Conditions *Fracture of left femur*
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following: *15/9*(a) Accident, suicide, or homicide *Accident*(b) Date of occurrence *Aug. 1943* *7 P*(c) Where did injury occur? *1918 Chelsea Rd*
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? *Home* While at work? *No*
(Specify type of place)(e) Means of injury *Fall on floor*23. Signature *L. Herman Williams*Address *Md. Gen Hosp* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Approved by *Harold J. Malcus, M.D.* *Oct. 12, 1943*

G 09039

BALTIMORE CITY HEALTH DEPARTMENT

G 09039

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3329 Alto Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3329 Alto Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LINDSAY B. FOSTER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 217-12-0043

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

Martha A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/1881

8. AGE: Years

61

Months

10 9

Days

27 7

If less than one day

hr.

min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual Occupation

Carpenter & Plumber

11. Industry or business

12. Name

George Foster

13. Birthplace

Ireland

14. Maiden Name

Eliza Burton

15. Birthplace

Canada

16 (a) Informant R. E. Soulsby

(b) Address 3329 Alto Rd.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/14/43

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a) OCT 13 1943

(b) Date of death

OCT 13 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1943 at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1943, to Oct 12, 1943, and that I last saw him alive on Oct 11, 1943.

Immediate cause of death

Acute dilatation of heart

Due to myocarditis

Due to Arterio-sclerosis

Other Conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Walter D. Rubelt

M. D.

Address

222 Harrison

Date signed

OCT 13/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09040

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2328 Ocala Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ruth nee Poland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

69

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-12-43

at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Oct 12 1943 and that I last saw him alive on Oct 12 1943

Immediate cause of death

Carcinoma of Stomach with Metastases

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

10/13

OCT. 13 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09041

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3405 E. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yr. 8

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME

Carmela Febo

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ottavio Febo

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) August 15 1886

8. AGE: Years Months Days If less than one day

57

1

26

hr.

min.

9. Birthplace Roma Italy

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

12. Name Salvatore Scandagliato

13. Birthplace Italy

14. Maiden Name Maria Fornai

15. Birthplace Italy

16 (a) Informant Ottavio Febo (Husband)

(b) Address 3405 E. Pratt St.

17 (a) Burial (b) Date thereof Oct. 14 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Co.,

Location Belair Rd. Balt. Md.

18 (a) Funeral director Franco Della Torre

(b) Address 52 N. Morley St.

19 OCT 18 1943

Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1943 at 10⁰⁰ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1943 to 10-5 1943, and that I last saw her alive on 10-5 1943.

Immediate cause of death

Carcinoma Left Breast

Due to

Due to

Other Conditions metastases to lungs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

George Govatos

M. D.

Address 101 W. Redd St Date signed 11-11-43

Duration

3 yrs

6 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

440473 09012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09012
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Helen May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-3-83

8. AGE:

Years

Months

Days

If less than one day

59

10

8

hr.

min.

9. Birthplace

Texas

(Town, county, and state)

10. Usual Occupation

Dress Designer

11. Industry or business

FATHER
MOTHER

12. Name

John Clay

13. Birthplace

ARK.

14. Maiden Name

Minnie Martin

15. Birthplace

Tenn

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a)

Cremation

(b) Date thereof 10-13-43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

London Park

Location

13 alle.

18 (a) Funeral director

Shirley M. Moore Co.

(b) Address

108 W North Ave.

19

OCT 13 1943

(b)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

101 Goodale Rd

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 11

1943

at 1045 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1943 to Oct 11 1943, and that I last saw her alive on Oct 11 1943.

Immediate cause of death

Cerebral embolism

Duration

Due to

Follicular lymphoblastoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. R. Freeman Jr.

M. D.

Address Johns Hopkins Hospital

Date signed 10/12

G 09043

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09043
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 12 W. 25th. Street
(c) Hospital or institution:
at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) XXXXX

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

ESTHER PARKER ELLINGER

3 (b) If veteran, name war
NONE3 (c) Social Security Account
No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife -----

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1893

8. AGE: Years 49 Months 10 Days 8 If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business Roland Park Country School

12. Name Clarence M. Ellinger

13. Birthplace Baltimore, Maryland

14. Maiden Name Theodora H. CANNON

15. Birthplace Salisbury, Maryland

16 (a) Informant Mrs. Theodora M. Ellinger (Mother)

(b) Address 12 W. 25th St., City

17 (a) Cremation (b) Date thereof Oct. 12, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Av. (W.F. Woodard, Suc.)

19 (a) OCT 13 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto. City

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)(d) Street No. 12 W. 25th. St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1943, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Oct 11 1943, and that I last saw her alive on Oct 11 1943.

Immediate cause of death

Embolism

Duration

1 day

Due to

Carcinoma (primary)

9 mos

Due to

sinus
Biopsy showed carcinoma

Other Conditions

(met)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

Signature J. Frederick Leary

Address Temple Garden St. Date signed Oct 12 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09044
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *844 W. Lombard St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *18*(e) Length of stay in Baltimore (yrs., mos., or days) *26 yrs*

3 (a) FULL NAME

Advil Walter

3 (b) If veteran, name war

3 (c) Social Security Account

No. *220-01-5254*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age *✓* years7. Birth date of deceased (mo., day, yr) *Jan 6, 1878*

8. AGE: Years Months Days If less than one day

65 *8* *26* *25* *hr* *min*9. Birthplace *South Carolina*

(Town, county and state)

10. Usual Occupation

11. Industry or business

12. Name *Augusta Walter*13. Birthplace *South Carolina*14. Maiden Name *Walter*15. Birthplace *South Carolina*16 (a) Informant *Mrs Mary E. Surwick*(b) Address *844 W. Lombard St.*17 (a) *burial* (b) Date thereof *10/14/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Olivet Cem*Location *2909 Spingewood Rd*18 (a) Funeral director *John Howard Fox*(b) *Huntington Williams*(Date rec'd by registrar) *OCT 13 1943*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *844 W Lombard St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 11, 1943* at *4 P. M*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 9* 19*43* to *Oct 11* 19*43*, and that I last saw him alive on *Oct 11* 19*43*.

Immediate cause of death

Cerebral hemorrhage *2 days*

Due to

Due to *arterio-sclerosis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *J. Harry Glassman*Address *753 W. Fayette St* Date signed *Oct 13 1943*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09045

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09045
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days

(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

3 (a) FULL NAME

John J. Campion

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

N

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/43

8. AGE: Years Months Days If less than one day

22 days

hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John J. Campion

13. Birthplace Baltimore, Md.

14. Maiden Name Antoinette, Stock

15. Birthplace Baltimore, Md.

16 (a) Informant John J. Campion

(b) Address 405 Rock Glen Rd

17 (a) (b) Date thereof 10/14/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Baltimore

Location 4300 Old Federal Rd

18 (a) Funeral director John J. Campion

(b) Address 901 Proctorville

19 OCT 13 1943

Registrar

VS 154

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 405 Rock Glen Rd.

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1943, at 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/ 1943, to 10/13 1943
and that I last saw him alive on 10/13 1943

Immediate cause of death

Cardio-Respiratory Failure

Due to

Due to

Premature Birth.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. B. Sylvia

Address

Date signed 10/13/

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09046
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **9**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1801 Riggs Avenue**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME **Theodore Andrew Smith**

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No. **-**

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Lollie Agnew**
(Deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **10/15/1869**

8. AGE: Years **73** Months **11** Days **26** If less than one day
hr. min.

9. Birthplace **Baltimore, Md.**

10. Usual Occupation **Plasterer - 20 yrs. ago**

11. Industry or business

12. Name **Frederick Smith**

13. Birthplace **Germany**

14. Maiden Name **Catherine Puls**

15. Birthplace **Maryland**

16 (a) Informant **Records, U.S. Marine Hospital**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10/15/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Balis National**
Location **Frederick Road**

18 (a) Funeral director **G. Lee Oiler**

(b) Address **4644 York Road**

OCT 13 1943

VB 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **October 11, 1943** at **5:05 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 2, 1943** to **Oct. 11, 1943** and that I last saw him alive on **Oct. 11, 1943**

Immediate cause of death **Advanced carcinoma of the stomach with metastasis to the liver**

Duration

Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **No operations**

Major findings of operations

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **J. C. Miller**

Address **Baltimore, Md.**

Date signed **10/12/43**

Va-15787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09047

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **9 mos.**
(e) Length of stay in Baltimore (yrs., mos., or days) **9 mos.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mass.** (b) County
(c) City or town **Boston**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **No. 2 Webster Place**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME

MAGNUS ANDREAS JENSEN

3 (b) If veteran, name war

3 (c) Social Security Account
No. **015-18-3560**

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced **Single**

6 (b) Name of ~~husband~~ **friend** **Albert Frietas**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 11, 1894**

8. AGE: Years Months Days If less than one day
49 **7** **26** hr. min.

9. Birthplace **Norway**
(Town, county, and state)

10. Usual Occupation **Cook - MS**

11. Industry or business

12. Name **Jens Jensen**

13. Birthplace **? Norway**

14. Maiden Name **Oliver Eksat**

15. Birthplace **? Norway**

16 (a) Informant **Records, U.S. Marine Hospital**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10/14/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **St. Marys**
Location **Rolands and**

18 (a) Funeral director **A. Lee Oler**

(b) Address **4644 York Road**

19 (a) **William M. R.** (b) **William M. R.**
(Date rec'd) (Signature) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **October 7, 1943** at **12:55M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Jan. 20, 1943** to **Oct. 7, 1943** and that I last saw him alive on **Oct. 7, 1943**.

Immediate cause of death **Carcinoma, squamous of the larynx, primary, advanced, post-operative & radiation.**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **1/29/43** **Laryngofissure with removal of tissue; Sequestrectomy of thyroid cartilage; & sequestrectomy of cricoid cartilage. Findings: Carcinoma as above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **J. C. Quinn**

Address **Baltimore, Md.**

Date signed **10/7/43**

MS-43866

OCT 13 1943

G 09048

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09048

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *P.R.R. Transfer Yard*
 (c) Hospital or institution: *Franklin Sq. Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *2-0-9*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *804 N. Calvert Street*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME *William A. Suffer*3 (b) If veteran, name war *No* 3 (c) Social Security Account No. *241-10-7127*4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced. *Married*6 (b) Name of husband *Addie* 6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) *Jan. 17-1913*8. AGE: Years *30* Months *8* Days *16* If less than one day hr. min.9. Birthplace *North Carolina* (Town, county, and state)10. Usual Occupation *Railroad Flagman*11. Industry or business *P.R.R. Co*12. Name *James P. Suffer*13. Birthplace *North Carolina*14. Maiden Name *Otha Beckett*15. Birthplace *North Carolina*16 (a) Informant *Addie Suffer*(b) Address *804 N. Calvert St. Baltimore*17 (a) *Removal* (b) Date thereof *Oct 13-43* (month) (day) (year)(c) Cemetery or crematory *Bessemer*Location *Bessemer N.C.*18 (a) Funeral director *William Cook Inc*(b) Address *1217 S. Paul Street Baltimore*

OCT 13 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-13-1943* at *2* A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

*Fractured skull**Cervical vertebrae*

Due to

Other Conditions *Crushed chest etc*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *10-13-43* at *3:00* A.M.(b) Where did injury occur *Between P.R.R. Transfer Yard, Maryland*(c) Did injury occur at home, on farm, industrial place, in public place? *Industrial* While at work? *Yes*(d) Means of injury *Crushed between freight cars*23. Signature *Howard J. Williams* M.D.Date signed *10-13-43* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The subject's age is especially important. Physicians: please write the causes of death clearly and legibly.

6 09049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09049

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2211 Rogers Ave*

(c) Hospital or institution:

Home for the Aged of the Methodist Church

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Lydia C. Woodward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband *William D. Woodward*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Mar 13 1914*

8. AGE: Years Months Days If less than one day
69 6 28 hr. min.

9. Birthplace *Balto Md.*
(Town, county, and state)

10. Usual Occupation *Domestic*

11. Industry or business *Home for the Aged*

12. Name *David D. Crist*

13. Birthplace *Balto. Md.*

14. Maiden Name *Mary Elizabeth*

15. Birthplace *Balto. Md.*

16 (a) Informant *Records - Home for the Aged*

(b) Address *of the Methodist Church*

17 (a) *Burial* (b) Date thereof *10/14/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Olivet*

Location *Balto. Md.*

18 (a) Funeral director *William D. Crist*

(b) Address *1217 St. Paul St*

19 (a) *13 1040* (b) *Thurston Williams, M.D.*
by registrar

VB 154

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *2211 Rogers Ave*
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 11 1943* P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Dec 15 1942* to *Oct 11 1943*, and that I last saw him alive on *Oct 11 1943*.

Immediate cause of death *Cerebral Hemorrhage*

Due to *Arterio sclerosis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Arthur J. Davis*

Address *800 W 38th St*

Date signed *10-12-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09050

BALTIMORE CITY HEALTH DEPARTMENT

G 09050

CERTIFICATE OF DEATH 477

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3112 Hollins Ferry Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3112 Hollins Ferry Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George W Schurabeland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary G

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1878

8. AGE: Years Months Days If less than one day

68

7

14

15

hr.

min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Conrad

13. Birthplace German

14. Maiden Name Hannah O'Donovan

15. Birthplace Ireland

16 (a) Informant Wife

(b) Address 3112 Hollins Ferry Rd

17 (a) Burial (b) Date thereof 10/14/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto city

18 (a) Funeral director Edward J. Sullivan

(b) Address 2359 Wash Blvd

DCT 1913 1943

Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1943 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 11, 1943.

and that I last saw him alive on Oct 11 1943.

Immediate cause of death

Carcinoma of lung

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Schafeld

Address 101 W. 11th St. M. D.

Date signed 12/13/43

Duration

Jan 1943
8 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09051

BALTIMORE CITY HEALTH DEPARTMENT

G 09051

CERTIFICATE OF DEATH 124 B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2113 Main St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2113 Main St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ida May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1876

8. AGE:

Years

Months

Days

If less than one day

67

0

16

hr.

min.

9. Birthplace W Va

(Town, county, and state)

10. Usual Occupation

Grocery clerk

11. Industry or business

MOTHER: FATHER:

12. Name

Eli Stucker

13. Birthplace

Md.

14. Maiden Name

Clara Engle

15. Birthplace

W Va

16 (a) Informant

Ida May Stucker

(b) Address

2113 Main St

17 (a)

Burial, cremation, or removal

(b) Date thereof 10/14/43

(c) Cemetery or crematory

Mt Olivet Cem

Location

Frederick Rd Balto City

18 (a) Funeral director

Edward Louisa

(b) Address

2359 Wash Blvd

19 (a)

(b)

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1943 at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1943, to Oct 11 1943, and that I last saw him alive on Oct 10 1943

Immediate cause of death

Coronary thrombosis of the heart

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

R O. Glasser

2328 Ballin Henry St

Date signed 10/14/43

Duration

14 hr

4 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 13 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09052
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

OCT 14 1943

Registrar

Approved: Robert L. Graham M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1943 to Oct. 13 1943, and that I last saw her alive on Oct. 13 1943.

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09053
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 09053
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 0

(e) Length of stay in Baltimore (yrs., mos., or days) 0 0 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1606 Vincent Court

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Scroggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1943

8. AGE: Years Months Days If less than one day
10 hr. 15 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name Howard Scroggins

13. Birthplace Annapolis, Maryland

14. Maiden Name Loretta Gross

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address Johns Hopkins Hospital

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL OCT 13 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 13 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1943 at 9:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1943 to Sept. 21 1943, and that I last saw him alive on Sept. 21 1943.

Immediate cause of death Prematurity
Atelectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. P. Hannah

M. D.

Address Johns Hopkins Hospital Date signed 9-30-43

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

v. s. 3

09054

HEALTH DEPARTMENT—CITY OF BALTIMORE

09054

CERTIFICATE OF DEATH

157M

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 *Scumble St.* St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. 802 *Scumble St.* St., Ward 25-5

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. Color or Race *W* 5. Single, Married, Widowed, or Divorced (write the word) *✓*

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

6. DATE OF BIRTH (month, day, year) *Oct 9, 43*

7. AGE Years Months Days If LESS than 10 min. *10 min.*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *L*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *✓*
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Baltimore* (State or country)

13. NAME *Tom Dunn*
14. BIRTHPLACE (city or town) *Georgia* (State or country)

15. MAIDEN NAME *Ronnie Kelly*
16. BIRTHPLACE (city or town) *Florida* (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place *UNIVERSITY MEDICAL SCHOOL OCT 13 1943*

19. UNDERTAKER *Commissioner of Health*

20. *OCT 13 1943* *Wilmington, Delaware*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *10/9*, 19*43*

22. I HEREBY CERTIFY, That I attended deceased from *10/9*, 19*43*

I last saw him alive on *10/9/43*, 19*43* Death is said to have occurred on the date stated above at *4:30* p.m.

The principal cause of death and related causes of importance were as follows:

monstrous

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19*43*

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *W. B. Rubin* M. D.

(Address) *2030 Calver Ave*

0438

G 09055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Boy Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-48

8. AGE: Years Months Days If less than one day

18 hr. min.

9. Birthplace

Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

CARRIE

15. Birthplace

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL OCT 13 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19

OCT 13 1943, Huntington Williams, M.D.
(Date read by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

FORT HOWARD

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 5

1943

at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1943 to Oct 5 1943, and that I last saw him alive on Oct 5 1943.

Immediate cause of death

Prematurity

Duration

1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Oscar Rando

Address Johns Hopkins Hosp.

Date signed 10/6/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09056
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. yrs., mos., or days: 18
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Mon

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 N. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Lee Smith

3 (b) If veteran, name war none 3 (c) Social Security Account No. none

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 Months 10 Days 0 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Oscar Smith

13. Birthplace Ky

14. Maiden Name Bessie Smith

15. Birthplace Ky

16 (a) Informant Bessie Smith

(b) Address 1124 N. Lombard St

17 (a) Burial (b) Date thereof 10-14-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Olivet Cem
Location Trudolph Ave City

18 (a) Funeral director Robert J. Brooks

(b) Address 338 Hollins Street

19 (a) OCT 14 1943 (b) Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/1943 10:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1943 to 10/12 1943, and that I last saw him alive on 10/12 1943.

Immediate cause of death myocardial infarction

Due to

Due to

Other Conditions stitching, medical possible from abuse.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: YES

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. L. French

Address Union Hosp. City Date signed 10/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 09057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

09057
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 708 W. Mulberry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 708 W. Mulberry St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Andrew Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8/14/43

8. Age

Years

Months

Days

If less than one day

1 4 9 28

hr.

min.

9. Birthplace

Baltimore MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Tom Mc Clary

13. Birthplace

MD

14. Maiden Name

Francis Bailey

15. Birthplace

MD

16 (a) Informant

Edna Bayles

(b) Address

70 E. W. Mulberry St

17 (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 10 14 43
(month) (day) (year)

(c) Cemetery or crematorium

W. Auburn Cem

Location

Baltimore MD

18 (a) Funeral director

William A Jackson

(b) Address

916 Penna ave

19 (a)

Date rec'd by registrar

(b)

10/14/43

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 12 - 19 42 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 11/19/43, to 10 - 12 - 19 42; and that I last saw him alive on 10 - 11 - 19 43.

Immediate cause of death Congenital Heart Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. L. French

Address Univ. Hosp. Date signed 10/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09058
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HARRY Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 9, 1927

8. AGE:

Years

Months

Days

If less than one day

18

97

3

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

General Helper

11. Industry or business

FATHER
MOTHER

12. Name

HARRY Miller

13. Birthplace

Md

14. Maiden Name

BERTHA Preston

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct 15

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore Cem

Location

City

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2004 E. Orleans St

19 (a)

(b)

(Date rec'd by registrar)

Registrar

OCT 14 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1712 N Bethel

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 12

1943

at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1943 to Oct 12 1943, and that I last saw him alive on 10-12 1943.

Immediate cause of death respiratory failure

Duration

10 min

Due to

meningitis

18 hrs

Due to

brain abscess

3 wks

Other Conditions

rt lat strabismus life
otitis (left)

(Include pregnancy within 6 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

T.B. Schwarz

M. D.

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09059

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 236 N. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna M. Nauman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Louis Nauman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1894
8. AGE: Years 49 Months 1 Days 27 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home
11. Industry or business

12. Name Charles Lang
13. Birthplace Baltimore
14. Maiden Name Theresa Rober
15. Birthplace Baltimore

- 16 (a) Informant Louis Nauman
(b) Address 236 N. Chester St

- 17 (a) Burial (b) Date thereof Oct 15
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location City

- 18 (a) Funeral director Willrich Funeral Home
(b) Address 2004 E. Orleans St

- 19 (a) Oct 14 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12th 1943 2-AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1943 to Oct. 14 1943, and that I last saw him alive on Oct. 14 1943.

- Immediate cause of death
acute cardiac dilatation
Due to general condition

Other Conditions

- (Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

- (e) Means of injury
23. Signature L. C. Solihol
Address 447 N. Kenwood Ave Date signed 10/13/43

Duration

1 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09060

Registered No.

09060

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Cory Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Balto.(c) City or town Bursalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 65 Mellon Spring Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert Head

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Dora Head

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.)

Sept 6 - 1901

8. AGE:

Years

Months

Days

If less than one day

42

1

6

hr.

min.

9. Birthplace

Atlanta

Ga

(Town, county, and state)

10. Usual Occupation

Machinist

11. Industry or business

Bethlehem Steel

FATHER
MOTHER

12. Name

James H Head

13. Birthplace

Ga

14. Maiden Name

Dora Martin

15. Birthplace

Ga

16 (a) Informant

Mrs Dora Head

(b) Address

65 Mellon Spring Rd

17 (a)

Removal

(b) Date thereof

Oct 14th

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Atlanta Ga

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2001-F. Delap

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-12-

1943, 9²⁵ PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Bullet wound of brain

Due to

Other Conditions

Supremacy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

10-2-43

4 P M

(b) Where did injury occur?

65 Mellon Spring Road

(c) Did injury occur at home, on farm, industrial place, in public place?

Home

While at work?

no

(d) Means of injury

22 Cal. Rifle

23. Signature

Honour. Williams

M.D.

Date signed

10-13-43

Medical Examiner.

VR 10

OCT 14 1943

especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

209061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121

6-09061
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/13 1943 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1943 to 10/13 1943, and that I last saw him alive on 10/13 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Intussusception with gangrenous appendix of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09062

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 14 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 10/11/43 to 10/12/43

and that I last saw him alive on 10/12/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Address

Designated

M. D.

G 09063

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1860 ✓ G 09063
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

President Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2520 Madison Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Percy Ridout

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or
divorced.

Widow

6 (b) Name of husband or wife

Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 11, 1891

8. AGE:

Years

Months

Days

If less than one day

52

4

29

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Bootblack

11. Industry or business

FATHER
MOTHER

12. Name

William Ridout

13. Birthplace

Baltimore, Md.

14. Maiden Name

Ella Blake

15. Birthplace

Baltimore, Md.

16 (a) Informant

Edna H. Nickerson

(b) Address

3520 Madison Ave.

17 (a)

Burial

(b) Date thereof

Oct. 14, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

Mr. Geo. H. Holland

Address

1631 Druid Hill Ave.

19 (a)

OCT 14 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/10 1943 at 3:30 PM

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Pulmonary Embolism. (H.S.M.)

Due to Fracture Femur left.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of
death, fill in the following:

(a) Date of injury

10/6/43 12/3 machine

(b) Where did injury occur?

On Street

(c) Did injury occur at home, on farm, industrial place, in public
place? Public Place While at work? —

(d) Means of injury

Fall

23. Signature

Hugh B. McElhenny

Date signed 10/10/43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09064

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09064
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EDWARD C EVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Charlotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-4-87

8. AGE:

Years

Months

Days

If less than one day

55

10

10

hr.

min.

9. Birthplace

VA

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

EDWARD EVANS

13. Birthplace

VA

MOTHER

14. Maiden Name

HATTIE CRAWFORD

15. Birthplace

VA

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a) Removal

(b) Date thereof 10-14-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Alexandria, Va

18 (a) Funeral director

Wm. J. Tinsley & Son

(b) Address

North & Penna Ave

19 (a)

OCT 14 1943

(b)

H. H. H.

2. USUAL RESIDENCE OF DECEASED:

(a) State VA

(b) County

(c) City or town

ALEXANDRIA

(If outside city or town limits, write RURAL and give town)

(d) Street No.

15 W. DALLAY AVE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT 14

1943, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1943, to Oct 14 1943, and that I last saw him alive on Oct 14 1943.

Immediate cause of death

Right sided

heart failure

(See pulmonary)

Due to

pulmonary fibrosis

Due to

Chronic Bronchitis

Other Conditions

Arterio Sclerotic

heart disease.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. S. Cross

M. D.

Address

2, H. H.

Date signed 10-14-43

IL-84143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09066
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life
(f) FULL NAME

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 N. Fremont Ave.
(e) Citizen of foreign country? _____ (If rural give location)
If yes, name country _____ (Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war Edie Young (Ada)

4. Sex F	5. Color or race C	No. 6 (a) Single, married, widowed, or divorced. ?
-------------	-----------------------	--

6 (b) Name of husband or wife ?
6 (c) If alive, give age years
7. Birth date of _____

7. Birth date of deceased (mo., day, yr.) **Jan. 7 1878**

8. AGE: Years			Months	Days	Jan. 7 1878 If less than one day hr. min.
65 ?			? 9	?	

9. Birthplace Id. (Town, county, and state)

10. Usual Occupation _____ (Town, county, and state)

11. Industry or business

12. Name..... ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Oct 19-1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Not

(c) Cemetery or crematory Not known
Location _____

18 (a) Funeral director. *La Brook*

(b) Address 1463 N. Carey St

OCT 14 1943 (b) *Hunter & Naigum, M.F.*

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1982, at 2:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1982, to 10-6 1982, and that I last saw him alive on 10-8 1982.

Immediate cause of death

Chapel accident
Due to Robert Halliburton

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.

(a) Accident, suicide, or homicide.

(b) Date of occurrence.

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? (City or town) (County) (State)
(Specify type of place) While at work?

(c) **Means of injury.**

23. Signature Tone PLAM

Address RT 004

Date signed 10/1/64 M. D.

08067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09067
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 14 1943

(Date filed by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write R.U.S. and give town)

(d) Street No.

(If not give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/43 19 10/10/43

and that I last saw him alive on 9/3/43 19

Immediate cause of death

Due to General arterio

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date

09068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09068
Registered No.

83126

78

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 4940 Eastern Avenue
 (c) Hospital or institution:
 BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 16 days
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Balto.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 811 N. Carey Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

James J. Watkins

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
Colored6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Margaret Watkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1911

8. AGE:	Years	Months	Days	If less than one day
	31	9	16	hr min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Louis Watkins

13. Birthplace ?

14. Maiden Name Elizabeth Thomas

15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Journal (b) Date thereof Oct 16, 43

(Burial, cremation, or removal) 9/11 Zion Cem.

(c) Cemetery or crematory

Location

18 (a) Funeral director My. Kate R. Williams

(b) Address 3929 N. Howard St

19 Oct 1, 1943

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1943, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1942 to 10-11 1943, and that I last saw him alive on 10-11 1943.

Immediate cause of death

Pulmonary TBC

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Hart

Address RCH

Date signed 10/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09069

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Sq. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 - 0 - 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State of Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 321 N. Arlington Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Butler Reese

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-07-8615

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Elvina Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 20, 1904

8. AGE:

Years

Months

Days

less than one day

39

3

19

hr.

min.

9. Birthplace

Georgia

(town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Charles Butler

13. Birthplace

Georgia

MOTHER

14. Maiden Name

Sarah?

15. Birthplace

Georgia

16 (a) Informant

Dorothy Butler

(b) Address

418 N. Palmer St

17 (a)

Burial

(b) Date thereof

Oct 18, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn Cem.

Location

18 (a) Funeral director

Mrs Kate R Williams

(b) Address

922 N. Schenck St.

19 (a)

Date received by registrar

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-9-1943, at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an

autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hon. J. L. L. L.

Medical Examiner.

M.D.

Date signed 10-10-43

OCT 14 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09070

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Calvert & Santiago St

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

3 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

853 Wellington St

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Ryer

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 14, 1904

8. AGE:

Years

Months

Days

If less than one day

39

0

28

hr.

min.

9. Birthplace

Texas

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

FATHER
MOTHER

12. Name

William H. Ryer

13. Birthplace

Penn.

14. Maiden Name

Maggie Stricker

15. Birthplace

Penn.

16 (a) Informant

Charles Ryer

(b) Address

853 Wellington St

17 (a)

Burial

(b) Date thereof

10/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Calhoun

Location

18 (a) Funeral director

B. Vernon Lannon

(b) Address

4611 Park Heights

19 OCT 14 1943

(b)

Thurgood Marshall

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 13, 1943, at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27, 1943, to Oct 12, 1943, and that I last saw him alive on Oct 12, 1943.

Immediate cause of death

Uremia
Septicemia

Due to

Subacute Bacterial

Due to

Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Robert B. Tunney

M. D.

Address Mercy Hosp.

Date signed 10/12/43

09071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09071
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 400 N. Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Peter H. Phillippi

3 (b) If veteran, name war

3 (c) Social Security Account
No. none4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced Married

6 (b) Name of husband or wife Grace B. Phillippi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1878

8. AGE: Years Months Days
65 7 27
If less than one day
hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Peter Phillippi

13. Birthplace Germany

14. Maiden Name Anna Regina Rascher

15. Birthplace Germany

16 (a) Informant Mrs. Grace B. Phillippi

(b) Address 400 N. Milton Ave.

17 (a) Burial (b) Date thereof Oct. 15/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Balto. Md.

18 (a) Funeral director Philip Shuring Son

(b) Address 2024 Orleans St.

OCT 14 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1943 at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11, 1943 to Oct. 11, 1943, and that I last saw him alive on Oct. 11, 1943.

Immediate cause of death

Coronary thrombosis

Duration

3 years

Due to arteriosclerosis

2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene P. Carson

M. D.

Address 514 Drury Lane Date signed Oct 12, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09072

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

1514 Division St

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

15 days

3 (a) FULL NAME

Richard T. Flood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9. 28. 43

8. AGE:

Years

Months

Days

If less than one day

—

—

15

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

FATHER

12. Name

Lorus Flood

13. Birthplace

N.C.

MOTHER

14. Maiden Name

Eleanor Clary

15. Birthplace

Md

16 (a) Informant

Lorus Flood

(b) Address

1524 Argyle Ave

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10 14 43

(month) (day) (year)

(c) Cemetery or crematorium

Mt. Auburn Cem

Location

Baltimore, Md

18 (a) Funeral director

William A. Jackson

(b) Address

916 Penna Ave

19 (a)

OCT 14 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1329 Argyle Ave

(If rural, give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 13, 1943, at 8¹⁵ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9.25. 1943, to 10.13. 1943, and that I last saw him alive on 10.13. 1943.

Immediate cause of death

bronchopneumonia

Duration

3 days

Due to

Due to

Other Conditions

prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James D. Carr

M. D.

Address 515 Maher St

Date signed 10.14.43

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G 09073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09073

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 741 W. Mulberry St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Carolyn Madison

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 - 1942

8. AGE: Years Months Days If less than one day

1 1 - hr. min.

9. Birthplace Balto, md.

(Town, county, and state)

10. Usual Occupation Performer

11. Industry or business

12. Name Percy James Madison13. Birthplace P.A.14. Maiden Name Mamie Spencer15. Birthplace P.A.16 (a) Informant Mamie Madison(b) Address 741 Mulberry St.17 (a) Burial (b) Date thereof Oct. 16, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. CalvaryLocation md.18 (a) Funeral director A. Halstead(b) Address 915 Grand Hill Ave.19 (a) Oct 14 1943 Registrar

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1943, at 6:45 P.21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☒, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Strangulation
due to ingestion of kerosene

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury Oct. 13 1943(b) Where did injury occur? 741 W. Mulberry St(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? no(d) Means of injury Swallowed kerosene23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed October 14, 1943

G 09074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09074
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital 26
8 days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5817 1/2 Belair Road

(If rural give location)

(e) If foreign born, how long in U. S. A.?

years

3 (a) FULL NAME

Joseph R. Petrosky

3 (b) If veteran, name war

World War II

3 (c) Social Security Account

No. 204-09-4121

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 21, 1919
24 Years 4 Months 13 Days If less than one day hr. min.

9. Birthplace Hazleton, Pennsylvania

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Shipyard Worker

12. Name Theodore Petrosky

13. Birthplace Poland

14. Maiden Name Anastasia Petrosky

15. Birthplace Poland

16 (a) Informant Sister, Jenny Barbarus

(b) Address Hazleton, Pennsylvania

17 (a) Removal (b) Date thereof 10/15/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. John the Baptist

Location Hazleton, Pennsylvania

18 (a) Funeral director M.W.E. DIPPELSON

(b) Address Lombard and Ann Sts.

19 (a) Date of death OCT 11 1943

(b) Place of death Huntington Williams Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1943 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1943 to Oct 13 1943, and that I last saw him alive on Oct 13 1943.

Immediate cause of death

Respiratory Failure
Due to meningitis due to meningococcus

Due to

Other Conditions

Anemia
Nephritis
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Stanley L. Blumenthal

Address Sydenham Hospital

Date signed 10/14/43

Duration

9 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09075

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor and Dukeland St

(c) Hospital or institution:

West Baltimore Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 912 Still St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Boy Caradiskey

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex M

5. Color or race W

6 (a) Single married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1943

8. AGE: Years Months Days If less than one day 4 hrs 30 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Harry Floyd Caradiskey

13. Birthplace Sunbury, Penna

14. Maiden Name Ella Louise Becker

15. Birthplace Danville, Penna

16 (a) Informant Mrs. H. F. Caradiskey

(b) Address 912 Still St.

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 14 1943 Commissioner of Health

18 (a) Funeral director

(b) Address

19 OCT 14 1943 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11th 1943 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11th 1943 to Oct. 11th 1943, and that I last saw him alive on Oct. 11th 1943.

Immediate cause of death

Intracranial hemorrhage

Duration

4 hrs

Due to Bruise Extraction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D.M. Dixon

Address 819 Medical Arts Bldg. Date signed 10/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09076

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bacon Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9

(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

3 (a) FULL NAME

Adolphus S. Bernard

3 (b) If veteran, name war

3 (c) Social Security Account

No. 161-03-5859

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice Knight

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 7, 1892

8. AGE: Years Months Days If less than one day

51 5 5 hr. min.

9. Birthplace Kansas City, Mo.

(Town, county, and state)

10. Usual Occupation Supervisor, Engineering

11. Industry or business Westinghouse Co.

12. Name Mark Gerard

13. Birthplace

14. Maiden Name Laura Simonson

15. Birthplace

16 (a) Informant Frank H. Grand

(b) Address 4011 Deepwood Road

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington Park

Location Greely Hall, Phila.

18 (a) Funeral director J. W. Mitchell

(b) Address 1900 Entaw Place

(c) Date of death 11-14-1943

(d) Signature of informant

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4011 Deepwood Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12-1943 at 4 P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Waldeis M.D.

Date signed 10-13-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09077

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09077
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **5610 Benton Heights Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **5610 Benton Heights Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edward Stichtenoth

3 (b) If veteran, name war

3 (c) Social Security Account
No. **212 20 2909**

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of husband or wife **Mathilde L.**
(nee Braun)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Sept. 24, 1866**

8. AGE: Years **77** Months **18** Days **18**
If less than one day hr. min.

9. Birthplace **Balto. Md.**
(Town, county, and state)

10. Usual Occupation **Tailor**

11. Industry or business **Singers Tailoring Co.**

12. Name **William Stichtenoth**

13. Birthplace **Germany**

14. Maiden Name **Augusta Joerr**

15. Birthplace **Germany**

16 (a) Informant **rs. Mathilde L. Stichtenoth**

(b) Address **5610 Benton Heights Ave.**

17 (a) **Cremation** (b) Date thereof **Oct. 15, 1943**
(Burial, cremation, or removal) (month) (day) (year)

(c) **Crematorium as crematory** **Greenmount**
Location **Greenmount Ave. & Oliver St.**

18 (a) Funeral director **Harry A. Witzke**

(b) Address **414 E. Edmondson Ave.**

(c) **John Williams, M.D.**
(Date signed) (Signature) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 12/43.** 19 **5:00 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 8** 19 **43** to **Oct 17** 19 **43**, and that I last saw him alive on **Oct 17** 19 **43**.

Immediate cause of death

Coronary thrombosis
Bronchitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Michael Grossfield**

Address **5407 Belair Rd.** Date signed **Oct 13, 1943**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09078
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Annie Hochenbery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Whester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/12/1898

8. AGE:

Years

Months

Days

If less than one day

45 46

8

2

hr.

min.

9. Birthplace

Hagerston Md

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

12. Name

Robert J. Fox

13. Birthplace

Hagerston Md

14. Maiden Name

Mary Thove

15. Birthplace

Hagerston Md

16 (a) Informant

Whester Hochenbery

(b) Address

Hagerston Md

17 (a)

Removal

(b) Date thereof

19/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rose Hill

Location

Hagerston Md

18 (a) Funeral director

Andrew Coffman

(b) Address

Hagerston Md

19 (a)

OCT 15 1943

Hagerston Md

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

M.D.

(b) County

Washington

(c) City or town

Hagerston Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

444 West Franklin St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/14

19 43:10 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10/10 19 43 to 10/14 19 43.

and that I last saw him alive on 10/14 19 43.

Immediate cause of death

Medullary failure

Due to

Posterior fossa P.O. remembrance

Due to

Brain tumor

Other Conditions

Ependymoma 4th Ventricle

(Include pregnancy within 3 months of death)

Date of operation

10/11/43

Major findings of operations

same

of autopsy

same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

R. H. Thompson

Address

University Hoop

M.D.

Date signed 10/14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09079

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Balto. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Scott Stonebraker

3 (b) If veteran, name war No
3 (c) Social Security Account No. NONE

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1942

8. AGE: Years 1 Months 15 Days 15 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Raymond LaMont Stonebraker

13. Birthplace Pennsylvania

14. Maiden Name Ada Nottingham

15. Birthplace West Virginia

16 (a) Informant Raymond L. Stonebraker

(b) Address 1617 Balto. St.

17 (a) Burial (b) Date thereof 10/15/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or place of interment Morland Park
Location Parkville, Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 OCT 15 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1943. at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1943. to Oct. 12 1943 and that I last saw him alive on Oct. 12 1943.

Immediate cause of death Cardiac-respiratory failure

Due to Bronchopneumonia

Due to Malnutrition

Other Conditions Drunken, otitis media.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Muzzey Jr. M. D.

Address 332 E. University Pkwy Date signed 10/12/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 69030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 201 E. Lafayette Ave
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ada Aubrey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 19 - 1902

8. AGE: Years Months Days If less than one day
41 1 20 hr. min.9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation

Roofer

11. Industry or business Security House Bldg. Co

12. Name (Unknown) Aubrey

13. Birthplace Va.

14. Maiden Name

15. Birthplace

16 (a) Informant Ada Aubrey

(b) Address 201 E. Lafayette Ave

17 (a) Burial (b) Date thereof 1918-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral directors William Bok was

(b) OCT 15 1943 St. Paul St.

19 (a) (b) (Date rec'd by registrar) Handwritten signature

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 at 9:50 M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Generalized

peritonitis

Due to Rupture of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following: Balto. Co. Md.

(a) Date of injury October 9, 1943 9:00 M

(b) Where did injury occur? Maywood - Sharon Ave

(c) Did injury occur at home, on farm, industrial place, in public
place? Industrial While at work? yes

(d) Means of injury Fall from roof

23. Signature Robert L. Fisher M.D.

Date signed October 14, 1943

G 09081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

G 09081
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3518 W. Belvedere Ave

(c) Hospital or institution:

Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days) 51 yr

3 (a) FULL NAME

John Leonard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife Anna Leonard

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1871

8. AGE: Years Months Days If less than one day

21

10

17

hrs.

min.

9. Birthplace

New York

(City, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name Dennis Leonard

13. Birthplace Ireland

14. Maiden Name Mary Rooney

15. Birthplace Ireland

16 (a) Informant Mrs Anna Leonard

(b) Address 3518 W. Belvedere Ave

17 (a) Burial (b) Date thereof Oct 16, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Joseph's

Location

Texas Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul st

19 OCT 15 1943

VB 124

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3518 W. Belvedere Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13, 1943, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27, 1943, to Oct 13, 1943, and that I last saw him alive on Oct 13, 1943.

Immediate cause of death

Pneumonia

Due to Hypertensive C-V.

Disease

Due to Sensitivity

Other Conditions Carcinoma of

Signed O. Metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert B. Tunney

Address Mercy Hosp Date signed 10/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09083

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09083

PLACE OF DEATH:

(a) Baltimore, City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

Spanish-American

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

63 10 28 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(Burial, cremation, or exhumation) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic myocardial

degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place? While at work?

(d) Means of injury.

23. Signature

Medical Examiner.

Date signed

October 14, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09084
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give township)
(d) Street No. 3711 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell J. Donnelly
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Margaret A. Donnelly
6 (c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.) Feb. 11 - 1901
8. AGE: Years 42 Months 8 Days 1 hr. min.
9. Birthplace Rock Hall Md.
(Town, county, and state)
10. Usual Occupation Peppercorn
11. Industry or business Whitefish Farm

12. Name Charles Donnelly
13. Birthplace Balto Md.
14. Maiden Name Catherine Lane
15. Birthplace Rock Hall Md.
16 (a) Informant Margaret A. Donnelly
(b) Address 3711 E. Baltimore St.
17 (a) Burial (b) Date thereof 10 - 15 - 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem
Location Balto Md.
18 (a) Funeral director J. H. Miller Inc.
(b) Address 2435 E. Ohio St.
OCT 15 1943 (b)
(Date set for burial)

MEDICAL CERTIFICATION
20. DATE OF DEATH 10 - 12 1943, at 2 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 27 1942, to 10 - 10 1943, and that I last saw him alive on 10 - 10 1943.

Immediate cause of death Pulmonary Embolism
Due to Thrombosis of the lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration of illness several years

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm Dew
Address 2901 E. Mon. St. Date signed 10/14/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

Huntington Williams, M.D.

G 09085

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09085

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2312 E. Preston St

(c) Hospital or institutions

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Parker

13. Birthplace Germany

14. Maiden Name Barbara Thomas

15. Birthplace Baltimore Md.

16 (a) Informant Catherine McLaughlin

(b) Address 2312 E. Preston St

17 (a) Burial (b) Date thereof 10-15-43

(c) Cemetery or crematory Woodlawn Cem

Location Baltimore Md.

18 (a) Funeral director John A. Milly

(b) Address 2435 E. Oliver St

OCT 15 1943

VB 116

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2435 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1943 at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1943 to Oct. 13 1943, and that I last saw him alive on Oct. 9 1943.

Immediate cause of death

Coronary Occlusion

Due to Coronary Occlusion

Due to

Other Conditions Chronic Int. Atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury R. S. Mover

23. Signature R. S. Mover M. D.

Address 516 Cathedral St. Date signed 10-14-43

Duration

0

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

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1 year

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1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

about

1 year

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 G 09086

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Redwood Greens St.*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 2*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County
(c) City *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1576 Elmtree St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna Zigas

3 (b) If veteran, name war

3 (c) Social Security Account No. *None*

4. Sex *F*

5. Color or race *W*

6 (a) Single, married, widowed, or divorced. *W*

6 (b) Name of husband or wife *William Zigas*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) *1882*

8. AGE: Years *61* Months *4* Days *1* If less than one day *1* hr *1* min

9. Birthplace *Lithuania*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Yessierov*

13. Birthplace *Lithuania*

14. Maiden Name

15. Birthplace *Lithuania*

16 (a) Informant *Mrs. Anna Vergas*

(b) Address *1200 S. Maryland, Balto.*

17 (a) *burial* (b) Date thereof *10 16 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Cross*

Location *Pelley Highway*

18 (a) Funeral director *Charles W. Friedman*

(b) Address *637 Washington Blvd*

19 (a) Date of death *OCT 13 1943* (b) Date of death *10 13 1943*

20 (a) Date of death *OCT 13 1943* (b) Date of death *10 13 1943*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-13 1943 at 11:35 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-12 1943* to *10-13 1943*, and that I last saw her alive on *10-13 1943*

Immediate cause of death *Coronary Heart Failure*

Due to *Hypertensive C V Disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury *Car*

23. Signature *Ralph J. Chenoweth*

Address *University Hosp* Date signed *10/13/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09087

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09087

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2615 E. Preston St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
 (e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County ---
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2615 E. Preston St.
 (If rural give location)
 (e) Citizen of foreign country? --- (Yes or No)
 If yes, name country ---

3 (a) FULL NAME

Charles W. Maccubbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Katharine Norris
 6 (c) If alive, give age --- years

7. Birth date of deceased mo., day, yr March 3, 1858

8. AGE: Years 85 Months 7 Days 11 If less than one day
 -- hr. --- min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual Occupation None

11. Industry or business ---

12. Name Charles T. Maccubbin
 13. Birthplace Maryland
 14. Maiden Name Margaret Kirk
 15. Birthplace Maryland

16 (a) Informant Mrs. Margaret M. Dudley
 (b) Address 2615 E. Preston Street

17 (a) Burial (b) Date thereof 10/16/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount
 Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks & Son
 (b) Address 805 N. Calvert Street

19 (a) (b) *Huntington Williams, Jr.*

OCT 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1943 to Oct. 14 1943 and that I last saw him alive on Oct. 13, 1943.

Immediate cause of death

ArteriosclerosisDuration
5 yrs.

Due to

Due to

Other Conditions Chronic Myocarditis 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature *H. W. Meeks* M. D.
 Address 1615 E. North Ave. Date signed 10-15-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09088
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)(d) Street No. 4220 Elmerode Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Wickes

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 75

Months 4

Days 24

If less than one day

hr

min

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name

Christopher Wickes

13. Birthplace

Not known

MOTHER

14. Maiden Name

Not known

15. Birthplace

Not known

16 (a) Informant

Sperry Lutz

(b) Address

4200 Elmerode Ave.

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Gruid Ridge

Location

Pikesville Md.

18 (a) Funeral director

Sperry Lutz

(b) Address

203 N. Broadway

19 (a)

Oct 15 1943

H. H. H. H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1943 at 3:30 M

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hypertension

cardiovascular

disease

Due to

Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert Lee Frazier M.D.

Medical Examiner.

Date signed October 14, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9376 09089

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *501 E Chase St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *10*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female Colored

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

Sept 16, 1879

8. AGE: Years Months Days

64

27

hr min.

9. Birthplace

Lebanon Kentucky
(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Philander Hamilton

13. Birthplace

Kentucky

MOTHER

14. Maiden Name

Clarissa J?

15. Birthplace

Kentucky

16 (a) Informant

Mother M. Teresa C. S. P.

(b) Address

501 E Chase St

17 (a) *Burial*

(b) Date thereof *Oct. 17/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cms.

Location

Fredrick Road

18 (a) Funeral director

Mrs. R. A. Elliott Dgt.

(b) Address

1129 N. Caroline St.

19 (a)

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

(c) City or town *Baltimore*

(If outside city or town line, write RURAL and give town)

(d) Street No. *501 E Chase St*

(If rural give location)

(e) Citizen of foreign country

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 13th 1943 at *11 A M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 1st 1943* to *Oct 13th 1943*, and that I last saw him alive on *Oct 13th 1943*

Immediate cause of death

Myocardial Infarction

Due to

Arterio-sclerosis

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: *No*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. A. Chilton

Address

100 N. Calvert St

Date signed

M. D.

Oct 14/43

OCT. 15 1943

William H. Hamilton

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09090

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2201 E Baltimore st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days 50 yrs

3 (a) FULL NAME

Isaac Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

1872

8. AGE: 71 Years

Months

Days

If less than one day

hr

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name Eugene Levin

13. Birthplace Russia

MOTHER

14. Maiden Name Bessie Linden

15. Birthplace Russia

16 (a) Informant Mrs Mollie Jacobs

(b) Address 2201 E Baltimore St

17 (a)

Buried

(b) Date thereof

Oct 15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Adair Israel

Location

North Point Road

18 (a) Funeral director

Sol Gorman Bros

(b) Address

1124 1st St N

19 OCT 10 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Balto

(d) Street No.

2201 e Baltimore St

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15

1943 . 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1937 to Oct 15 1943 and that I last saw him alive on Oct. 14 1943

Immediate cause of death

Chronic Myocarditis, chronic
Due to arterio-sclerosis, chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. H. C. C. C.

Address

2310 E. Calver

Date signed

10/15/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G09091

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G09091
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3704 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days 28
(e) Length of stay in Baltimore yrs., mos., or days

3 (a) FULL NAME

MARGARET LELIA ROWAN

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John H. D. Rowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1860

8. AGE: Years 63 Months 6 Days 17 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Andrew Sisselberger

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Mary Hunter

15. Birthplace Ireland

16 (a) Informant Mr. John S. Rowan

(b) Address 3704 Mohawk Ave.

17 (a) Burial (b) Date thereof 10/16/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 15 1943
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

- a State Md. b) County
c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
d) Street No. 3704 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1943 at 4:50 P

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1937 to Oct. 13 1943 and that I last saw him alive on Oct. 13 1943

Immediate cause of death

Memoria

Due to Chl. myocarditis

Due to Chl. nephritis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

Signature J. S. Sisselberger
Address 3704 Mohawk Ave. Date signed 10/15/43

Duration

10 days

10 yrs.

6 hrs

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09092

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4223 Belmar Ave
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 26
- (e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
- (d) Street No. 4223 Belmar Ave
(If rural give location)
- (e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME

- 3 (b) If veteran, name war none 3 (c) Social Security Account No. none

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced widowed

- 6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 25, 1869

8. AGE: Years 74 Months 2 Days 17 If less than one day hr. min.

9. Birthplace Catonville, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name Lomada Lindt

13. Birthplace Harpers Ferry, Va.

14. Maiden Name

15. Birthplace

- 16 (a) Informant Mrs. George Davis

- (b) Address 3658 Resnick Road

- 17 (a) Burial (b) Date thereof 10/15/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

- 18 (a) Funeral director Howard N. Blight

- (b) Address 4914 Belair Road

- 19 OCT 15 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1943, at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1943, to 10/13 1943, and that I last saw him alive on 10/12 1943.

Immediate cause of death
Chronic Myocarditis

Deep Senility

Due to

Other Conditions
Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur?
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
Specify type of place)
- (e) Means of injury

23. Signature John A. Walker

Address 6304 Belair Rd Date signed 9/13/43

Duration
unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09093
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 S. Curley St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 S. Curley St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Hirschman

3 (b) If veteran, name war 3 (c) Social Security Account No. 213-09-1031

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1882

8. AGE: Years 61 Months 5 Days 15 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business

12. Name Fredrick Hirschman

13. Birthplace Germany

14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant Paul Roth

(b) Address 640 S. Curley St.

17 (a) Burial (b) Date thereof 10 16 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park Cem. Location Fredrick Rd.

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson St.

19 (a) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 43 at 1:02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 43 to Oct 14 19 43. and that I last saw him alive on Oct 13, 19 43.

Immediate cause of death Coronary Sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Miletree F. Huntmark M. D.

Address 2529 Eastern Ave Date signed 10/14/43

Duration 4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

09095

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09095

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 430 N. Linwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

3 (a) FULL NAME

Clara L. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Garland Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1885

8. AGE: Years 57 Months 9 Days 23 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Thos Pierpoint

13. Birthplace Baltimore

14. Maiden Name Caroline Niedermair

15. Birthplace Baltimore

16 (a) Informant Dorothy Jenkins

(b) Address 440 N. Linwood Ave

17 (a) Burial (b) Date thereof Oct 18 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cmn Location Rural

18 (a) Funeral director William J. Fernald

(b) Address 2004 E. Illinois

19 (a) 15-1943 (b) H. H. Williams M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 430 N. Linwood Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13, 1943, 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1942 to Oct 13, 1943, and that I last saw her alive on Oct 13, 1943.

Immediate cause of death Diabetic Coma Duration Diabetic hyperkalemia (18 mos)

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Allen C. Fernald

Address 2131 E. Pratt St Date signed 10-15-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 15 1943

VS 100

43

G 09096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09096

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Woman's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Paul, Hendricks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1939

8. AGE: Years Months Days If less than one day
4 6 19 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

12. Name Edward D. Heubeck

13. Birthplace Md.

14. Maiden Name Frances Taylor

15. Birthplace Md.

16 (a) Informant Edward D. Heubeck

(b) Address 5201 Wilton Hgts. Ave

17 (a) Burial (b) Date thereof 10-14-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Lorraine Pk.
Location

18 (a) Funeral director Phoenix P. Pomeroy

(b) Address 3615-17 Chestnut Ave.

19 (a) Date of death 10-15-43 (b) Cause of death Rupture of liver, spleen and right kidney

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5201 Wilton Hgts. Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1943, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of liver, spleen and right kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury October 13, 1943 4:00 P.M.

(b) Where did injury occur? Wilton Hgts. Baltimore

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No

(d) Means of injury Hit by taxi

23. Signature Robert D. Frutkin M.D.

Medical Examiner

Date signed October 14, 1943

10-15-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09097
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1906 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

HELEN AGNES AUER

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Widow

6 (b) Name of husband or wife Philip P. Auer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1869

8. AGE: Years Months Days If less than one day
74 5 27 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Charles Fisher

13. Birthplace Balto.

14. Maiden Name Fredericka Glenn

15. Birthplace Va.

16 (a) Informant Mrs. C. E. Hood

(b) Address 2400 Harlem Ave.

17 (a) Burial (b) Date thereof 10/6/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 15, 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1943 at 1:18 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1943 to 10/14/43 and that I last saw her alive on 10/14/43

Immediate cause of death

Cancer of Breast 9 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. J. Tickner
Address 1945 W. N. Ave. Date signed 10/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09098

BALTIMORE CITY HEALTH DEPARTMENT

G 09098

CERTIFICATE OF DEATH 83a

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 700 W. 40th ST.

(c) Hospital or institution:

Home for Incurables 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs, 5 mos, 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore - 11
(If outside city or town limits, write RURAL and give town)(d) Street No. 700 W. 40th ST.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr. James B. George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 29, 1874

8. AGE:

Years

Months

Days

If less than one day

69

5

14

hr.

min.

9. Birthplace

Sykesville, Maryland
(Town, county, and state)

10. Usual Occupation

Prof. of Md. University

11. Industry or business

Not ailing

FATHER
MOTHER

12. Name

James George

13. Birthplace

Maryland

14. Maiden Name

Eugenie Barrett

15. Birthplace

Sykesville, Md.

16 (a) Informant

Home for Incurables

(b) Address

700 W. 40th ST.

17 (a)

Cremation

(b) Date thereof

10/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Crematory

Location

Baltimore, Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19

OCT 15 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1943, at 5:24 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1940, to Oct. 13 1943, and that I last saw him alive on Oct. 12 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

arteriosclerosis (essential)

20 yrs

Due to

Hypertension (essential)

20 yrs

Other Conditions

Right Hemiparesis

6 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature W. Drafter Harberger

Address 214 Medical Art Bldg signed 10/13/43

Duration

24 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

9099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09099

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1211 Scott St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1211 Scott St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

GEORGE BLAND BUCKMASTER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Fannie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1889

8. AGE: Years

54

Months

0

Days

20

If less than one day

hr.

min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation --

11. Industry or business

12. Name Joseph W. Buckmaster

13. Birthplace Calvert Co., Md.

14. Maiden Name Lucy South

15. Birthplace Pa.

16 (a) Informant Miss Lucy M. Buckmaster

(b) Address 1211 Scott St.

17 (a) Burial (b) Date thereof 10/16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 15 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 13 1943, and that I last saw him alive on Oct 13 1943.

Immediate cause of death

Chronic myocarditis
& heart failure.

Due to

Hypertension

Due to

Other Conditions

Generalized
redness
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Schuch

Address 309 Ames St. Date signed 10/14/43

Duration

2 years

2 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09100

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1803 Light St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Harry Broseker

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Emma Voelkel

Broseker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1881

8. AGE: Years

62

Months

8

Days

8

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business Own business-retired

12. Name Henry Broseker

13. Birthplace Maryland

14. Maiden Name Elizabeth Leiman

15. Birthplace Maryland

16 (a) Informant Mr. Robert H. Broseker

(b) Address 3307 Clifftont Ave.

17 (a) Burial (b) Date thereof 10/15/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1849 E. North Ave.

19 OCT 15 1943

Huntington Williams, M.D.
Registrar

HARRY HENRY BROSEKER

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1943 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1943 to Oct. 13 1943, and that I last saw him alive on Oct. 13 1943.

Immediate cause of death Metastatic

carcinoma

Due to carcinoma of prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul H. Lukats

Address 1213 Light St.

Date signed 10/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

9101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09101
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

Street address: 3333 N. Charles Street

Hospital or institution:

Charles Apartments

(d) Length of stay in hospital or inst. (yrs., mos., or days) XXXXX

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) ~~XXX~~ Baltimore City

(c) City or town

Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3333 N. Charles Street

(If rural give location)

(e) Citizen of foreign country?

NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

ELEANOR GOUCHER

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No.

NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 16, 1882

8. AGE:

Years

Months

Days

If less than one day

61

5

28

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

NONE

FATHER

12. Name Rev. John Franklin Goucher

13. Birthplace Nr. Pittsburgh, Penna.

MOTHER

14. Maiden Name Mary C. Fisher

15. Birthplace Cecil County, Maryland

16 (a) Informant Mrs. Jeanette G. Miller (sister)

(b) Address 213 Kemble Rd., Guilford, City.

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. -16-1943

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge Cemetery

Location

Pikesville, Maryland.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Av. (W.F. Wooden-Suc.)

OCT 15 1943

(Date rec'd by registrar)

H. Williams, M.D.

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1943, at 6 P. M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence

(Autopsy or Inquiry)

obtained by said find that said deceased came to his death on the day stated above.

(Autopsy or Inquiry)

Immediate cause of death

Atherosclerotic
cardiovascular

Due to

disease

Due to

Other Conditions As

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. L. Wallenrother

M.D.

Date signed 10-15-43

2nd Medical Examiner.

9102

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09102
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 15 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(g) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw h

alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

23. Signature

Address

Date signed

Duration

5 years

Myocarditis

Hypertension

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 09103

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1300 Lakeside Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1300 Lakeside Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Bernhard Henze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife *Emilie C.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 22, 1862*

8. AGE: Years *81* Months *-* Days *22* If less than one day hr. min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant *Valentine B. Henze*

(b) Address *1300 Lakeside Ave*

17 (a) *Burial* (b) Date thereof *Oct 19-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Lutheran Cem.*

Location *Burroughs N. Y.*

18 (a) Funeral director *Leonard J. Roth*

(b) Address *5305 Norfolk Road*

19 (a) (b)

OCT 15 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 14 1943* at *11:40 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 1942* to *Oct 14 1943*, and that I last saw him alive on *Oct 14 1943*

Immediate cause of death

Coronary Occlusion

Due to *far advanced generalized arteriosclerosis*

Due to *arteriosclerotic cardiovascular disease*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

E. Alessi

Date signed *10/15/43*

E. ALESSI

Duration

6 hrs

1 yr?
specify
year

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09104
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 218 E. Edge Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Samuel Richardson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 3, 1888

8. AGE:

Years

Months

Days

If less than one day

54119

hr.

min.

9. Birthplace

Amelia Co. Va.

(Town, county, and state)

10. Usual Occupation

Janitor

11. Industry or business

FATHER
MOTHER

12. Name

Louder Richardson

13. Birthplace

Amelia Co. Va.

14. Maiden Name

Florence Davis

15. Birthplace

Amelia Co. Va.

16 (a) Informant

Earl M. Luyck

(b) Address

202 E. Chesapeake Ave

17 (a)

Burial

(b) Date thereof

Oct. 16, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Long Green Cem.

Location

Long Green, Md.

18 (a) Funeral director

Mrs. George H. Hall

(b) Address

1631 Druid Hill Ave.

19 (a)

(Date rec'd by registrar)

(b)

Harold H. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

245 Roberts Street

(If rural, give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-12-1943, at 3 P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place?

While at work?

(d) Means of injury

23. Signature Harold H. Williams

M.D.

Date signed 10-13-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09105
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Green St.*

(c) Hospital or institution: *University Hospital*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *14*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1924 Madison Ave.*

(If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. *None*

4. Sex

Female Cal.

5. Color or race

6 (a) Single, married, widowed, or divorced *Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 1, 1943*

8. AGE: Years Months Days *1 40 12* less than one day hr. min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Katter Jann*

13. Birthplace *Sykesville, Md.*

14. Maiden Name *Jay Garland*

15. Birthplace *Baltimore, Md.*

16 (a) Informant *Jay Jann*

(b) Address *1924 Madison Ave.*

17 (a) *Burial* (b) Date thereof *Oct. 16, 1943*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Auburn*

Location *Baltimore, Md.*

18 (a) Funeral director *Mr. George H. Holland*

(b) Address *1631 Druid Hill Ave.*

19 (a) (b) *Thos. J. Williams, M.D.* Registrar

(Date rec'd by registrar) *OCT 15 1943*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/13 1943 8:25 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-10 1943* to *10/13 1943*, and that I last saw her alive on *10-13 1943*.

Immediate cause of death *Dehydration* Duration

Due to *nutritional Disturbance*

Due to

Other Conditions *Malnutrition*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *S. L. French*

Address *Univ. Hosp.* Date signed *10/13/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09106

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09106
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2027 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME anna Oszabiewski (Oszakowski)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife August
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years about 68 Months Days If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Not Known

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Catherine Karle

(b) Address 1198 Belmond Ave

17 (a) Burial (b) Date thereof 10-18-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Polish
Location German Hill Rd.

18 (a) Funeral director Wm. S. Blaskowski

(b) Address 2007 Eastern Ave

OCT 13 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1943 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943 to Oct 14 1943, and that I last saw her alive on Oct 14 1943.

Immediate cause of death Central apoplexy

Due to Hypertension & Ch. arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Israel Feingold

Address 2002 E. Pratt Date signed 10/17/43

Duration

acute

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09107

Registered No.

1. PLACE OF DEATH:
 Baltimore City, Maryland
 (b) Street address 3451 Chestnut Ave.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
 (e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3451 Chestnut Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME
George Washington Rosier
 3 (b) If veteran, name war
 3 (c) Social Security Account No. 717-078050

4. Sex male **5. Color or race** white **6 (a) Single, married, widowed, or divorced** married
 6 (b) Name of husband or wife Mary E. Rosier
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1878
8. AGE: Years 64 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Frankville Pa.
 (Town, county, and state)

10. Usual Occupation Passenger Conductor
11. Industry or business Pa. R. R.

12. Name William Thomas Rosier
13. Birthplace Md.
14. Maiden Name Sarah E. Wilson
15. Birthplace Pa.

16 (a) Informant Mary E. Rosier
(b) Address 3451 Chestnut Ave.

17 (a) Burial (b) Date thereof 10-16-43
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Dread Ridge
 Location

18 (a) Funeral director Walter R. McNamee
(b) Address 4114 Fall Road
19 (a) Oct 15 1943 Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct 13 19 43 at 11:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 19 43, to Oct 13 19 43
 and that I last saw him alive on Oct 13 19 43
 Immediate cause of death
Cerebral hemorrhage
 Due to
Cerebral Arteriosclerosis
 Other Conditions
Polymyositis
 (Include prognosis within 3 months of death)
 Date of operation
 Major findings of operations
 of autopsy

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur?
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature W. S. Smith
 Address 3427 Chestnut Ave. Date signed Oct 14 1943
 M. D.

PHYSICIAN
 Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09108

MD-84292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09108
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2333 E. Fayette St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Helen Szymanski

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isidore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1890

8. AGE: Years Months Days If less than one day

53

1

24

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph Novak

13. Birthplace Poland

14. Maiden Name Tiny Fredcyehowska

15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10/16/43.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Sedowski & Sons

(b) Address 1808 Eastern Ave

19 (a)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1943 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1943 to 10-12 1943, and that I last saw him alive on 10-12 1943.

Immediate cause of death

Hypertensive cardiovascular disease - sleepers etc

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul M. M.

Address B.C.H.

M. D.
Date signed 10/13/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 15 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09109
442064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09109
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

Baltimore

(c) City or town

Wundalk.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

61 Kensington Road.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Nick Nicholas

3 (b) If veteran, name war

3 (c) Social Security Account

No.

none

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Jenna

6 (c) If alive, give age

42 years

7. Birth date of deceased (mo., day, yr.)

10-2-42/89

8. AGE:

Years

Months

Days

If less than one day

54

0

17

hr.

min.

9. Birthplace

Greece

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

MOTHER: FATHER:

12. Name

Gregory Nicholas

13. Birthplace

?

14. Maiden Name

Aspercia

15. Birthplace

?

16 (a) Informant

Reynolds

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Tarpon, Springs Florida

18 (a) Funeral director

J. Francis Reese

(b) Address

Westminster, Md.

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct-14-

1943 at 12:10 P

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1943 to Oct 14 1943 and that I last saw him alive on Oct 14 1943

Immediate cause of death

Toxemia

Duration

Due to

Liver damage

Due to

? Subacute yellow atrophy

Other Conditions

obstructive Type

jaundice

(include pregnancy within 3 months of death)

Date of operation

10/1/43

Major findings of operation: No obvious

responsible pathology found.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 10/14/43

PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

441600
G 09110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 477

G 09110

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **1129 W Mulberry**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

EMMA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **5-11-78**

8. AGE: Years **65** Months **5** Days **1**
If less than one day hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

JANITOR

11. Industry or business

12. Name **William Chase**

13. Birthplace **Md**

14. Maiden Name **MARGARET**

15. Birthplace **Md**

16 (a) Informant **Records**

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **Oct. 16, 1943**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Auburn Cem**
Location

18 (a) Funeral director **Mrs. Kate R. Williams**

(b) Address **322 N. Lombard St.**

19 (a) **OCT 15 1943** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 12 1943**, at **1050 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 21 1943** to **Oct 12 1943**, and that I last saw him alive on **Oct 12 1943**.

Immediate cause of death **Coronary of Lung, left upper lobe**

Duration **2 mos. +**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **T B Schwartz**

Address **Johns Hopkins Hosp** Date signed **10-12**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09111

Registered No.

G 09111

ye

51B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Woodbrook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
Colored

6 (a) Single, married, widowed, or
divorced. Divorced

6 (b) Name of husband or wife Alice (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 28, 1868

8. AGE: Years Months Days If less than one day
74 10 15 hr min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Jacob Johnson

13. Birthplace Maryland

14. Maiden Name Katherine Prout

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Oct. 18, 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Kate R. Williams

19 OCT 15 1943
(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1943 6:10 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-20 1943 to 10-13 1943,
and that I last saw him alive on 10-13 1943.

Immediate cause of death

Pneumonia

Due to

Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-6-43

Major findings of operations:

alone

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald B. Hill

Address Baltimore City, Md. Date signed 10-14-43

Duration

7 days

3 wks

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 09112

BALTIMORE CITY HEALTH DEPARTMENT

G 09112

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Stoop

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 729 W. Saratoga St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Albert Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 20, 1943

8. AGE:

Years

Months

Days

If less than one day

76

24

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Alb. Chandler

13. Birthplace

Sumter S. C.

14. Maiden Name

Emma Jenkins

15. Birthplace

Sumter S. C.

16 (a) Informant

Emma Chandler

(b) Address

729 W. Saratoga St.

17 (a)

Burial

(b) Date thereof

Oct. 16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion Cem

Location

18 (a) Funeral director

Mrs. Katie R. Williams

(b) Address

322 N. Broadway St.

19 (a)

OCT 15 1943

(Date registered)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 at 5:30 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Infantile

diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature Robert L. Trotter M.D.

Medical Examiner.

Signed October 14, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09113

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09113

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of skin

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

OCT 15 1943

VB 156

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, limit write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT 13 1943 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/43 19 to 10/13/43 19 and that I last saw him live on 10/13 19

Immediate cause of death

Acute Coronary Failure

Due to

Arteriosclerotic Cordis

Due to

Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

Address

679 Washington Rd. Date signed 10/14/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 09114

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp. ✓

(d) Length of stay in hospital or inst. (year, month, or days) 13

(e) Length of stay in Baltimore (year, month, or days) 13

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

OCT 15 1943

(Date read by registrar)

Commissioner of Health

Christington Williams, Mrs.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

M

21. I certify that death occurred on the date above stated that I attended deceased from 9/17 1943, 9/30 1943, and that I last saw him alive on 9/30 1943.

Immediate cause of death

Duration

Cardiac Failure
Due to Congenital Heart Condition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 09115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09115

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution:

Mount Hope Retreat

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) About 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. Mount St. Agnes College
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Sister M. Bridget Conipp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 61 Months 3 Days 14 If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1943, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934 to Oct 15, 1943, and that I last saw her alive on Oct 15, 1943.

Immediate cause of death

Left cerebral hemorrhage

Due to Diabetes mellitus

Due to

Other Conditions Paranoid Psychosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

5 days

10 years

18 years

18 years

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

5-1943

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

G 09116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09116

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3100 Woodland Ave.

(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 212-09-0148

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Ellen Smith

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) Oct. 18, 1890

8. AGE:

Years 52

Months 11

Days 26

If less than one day

hr.

min.

9. Birthplace Baltimore Co. Md.

(Town, county, and state)

10. Usual Occupation Fireman Standard Oil

11. Industry or business

12. Name Joseph O. Smith

13. Birthplace Maryland

14. Maiden Name Emma Kramer

15. Birthplace Maryland

16 (a) Informant Mrs. Mary Ellen Smith

(b) Address 3100 Woodland avenue

17 (a) Burial (b) Date thereof 10/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director

(b) Address 118 N. Mt. Royal Ave.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1943, at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

occlusion

Cormey

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

Means of injury

Signature

Robert L. Graham

M.D.

Date signed October 14, 1943

Medical Examiner.

OCT 15 1943

Registrar

G 09117

BALTIMORE CITY HEALTH DEPARTMENT

G 09117

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1943 to Oct 12 1943 and that I last saw him alive on Oct 12 1943

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address 24-3 St Paul St Date signed 10/13/43

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

THESE WRITERS' SERVICES, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

09118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09118

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

09119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09119
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-03-899

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/13/43

10:30 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 9/16/43 to 10/13/43

and that I last saw him on 10/13/43

Immediate cause of death

Respiratory failure

Due to Uremia

Due to Chronic glomerulo

nephritis

Other Conditions

Congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date dictated

10/13/43

West Baltimore Hosp

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

10/13/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof (month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Date

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country

(f) If rural give location

(g) If yes, name country

(h) If yes, name country

(i) If yes, name country

(j) If yes, name country

(k) If yes, name country

(l) If yes, name country

(m) If yes, name country

(n) If yes, name country

(o) If yes, name country

(p) If yes, name country

(q) If yes, name country

(r) If yes, name country

(s) If yes, name country

(t) If yes, name country

(u) If yes, name country

(v) If yes, name country

(w) If yes, name country

(x) If yes, name country

(y) If yes, name country

(z) If yes, name country

(aa) If yes, name country

(ab) If yes, name country

(ac) If yes, name country

(ad) If yes, name country

(ae) If yes, name country

(af) If yes, name country

(ag) If yes, name country

(ah) If yes, name country

(ai) If yes, name country

(aj) If yes, name country

(ak) If yes, name country

(al) If yes, name country

(am) If yes, name country

(an) If yes, name country

(ao) If yes, name country

(ap) If yes, name country

(aq) If yes, name country

(ar) If yes, name country

(as) If yes, name country

(at) If yes, name country

(au) If yes, name country

(av) If yes, name country

(aw) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 15 1943

VB 140

For O.R.L. Brennan, Sr. Howard J. Blakeslee, M.D.

G 09121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09121

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5-14 Madison Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emma Garrett

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1889

8. AGE:

Year

Months

Days

If less than one day

not 54

hr.

min.

9. Birthplace

Va

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

George W. Jones

13. Birthplace

Dismal Co Va

MOTHER

14. Maiden Name

Constance

15. Birthplace

Va

16 (a) Informant

Edna Owens (daughter)

(b) Address

1407 McCallister St

17 (a)

Burial

(b) Date thereof

10/12/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

B-10

18 (a) Funeral director

Charles Alexander

(b) Address

1200 McCallister St

19 (a)

OCT 15 1943

(b)

H. H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/12/43 8:50 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Hugh B. McCallister

Medical Examiner

Date signed

10/13/43

09122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09122

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Levening B. Ruhl

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

M

5. Color of race

White

6 (a) Single married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/15/43

8. AGE:

Years

Months

Days

If less than one day

0

7

hr.

min.

9. Birthplace

Monkton, Md.

(Town, county, and state)

10. Usual Occupation

Baby

11. Industry or business

12. Name

Levening Ruhl

13. Birthplace

N. Carolina

14. Maiden Name

Gene Yatta

15. Birthplace

N. Carolina

16 (a) Informant

Levening Ruhl

(b) Address

Monkton, Md.

17 (a)

Burial

(b) Date thereof

Oct. 17, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Foster

Location

Newford, Md. (Monkton P.O.)

18 (a) Funeral director

Lester M. Brooks

(b) Address

Sparks, Md.

(a) OCT 15 1943

(b)

(Date rec'd by Registrar)

Huntington National Bank

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Monkton

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/15

1943, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1943 to Oct. 15 1943 and that I last saw him alive on Oct. 15 1943.

Immediate cause of death

Respiratory

Due to

Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Carl Meyer M.D.

Address

Mary Hospital

Date signed 10/15/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09123

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09123
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 OCT 16 1943 (b)

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/43 to 10/15/43, and that I last saw him alive on 10/15/43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09124

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1037 N. Fulton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1037 N. Fulton Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES N. BENSON

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Widower

6 (b) Name of husband or wife Ada M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1881

8. AGE: Years Months Days If less than one day
62 2 11 hr. min.9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Insurance Agent

11. Industry or business

12. Name Nicholas R. Benson

13. Birthplace Balto. Co.

14. Maiden Name Sarah Salamon

15. Birthplace Va.

16 (a) Informant Mrs. Gertrude Patterson

(b) Address 3920 Duvall Ave.

17 (a) Burial (b) Date thereof 10/16/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

OCT 16 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1943, at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct. 13, 1943, to Oct. 14, 1943,
and that I last saw him alive on Oct. 14, 1943.

Immediate cause of death

Coronary Thrombosis

Due to Coronary Atherosclerosis
& Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Harry Ashman

Address

1921 W. North Ave.

Date signed

10/16/43

Duration
1 week

8 yrs

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09125
Registered No. 09125

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2201 Orem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2201 Orem Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

GERTURDE SEVIER WHITNEY

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife Alvin O.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1892

8. AGE: Years Months Days If less than one day
51 3 13 hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Ward

13. Birthplace A. A. Co., Md.

MOTHER 14. Maiden Name Lola E. Sevier

15. Birthplace A. A. Co., Md.

16 (a) Informant Mr. Alvin O. Whitney

(b) Address 2201 Orem Ave.

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) Baldwin M.E. Cem.

(c) Cemetery or crematory
Location Crossroads, A. A. Co., Md.
WM. J. TICKNER & SONS

18 (a) Funeral director

(b) Address Baltimore, Md.

19 (a) OCT 16 1943
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1943, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943 to Oct 14 1943, and that I last saw him alive on Oct 14 1943.

Immediate cause of death

Cerebral Hemorrhage
Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 1621 W 24th Ave Date signed 10/18/43

Duration

1 day
7 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

93726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09126

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5 S Collington Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

Mr. Frank L. Gnau

3 (b) If veteran, name war

3 (c) Social Security Account

No. 812-05-4505

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife HELEN

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) NOV 3-1889

8. AGE: Years 53 Months 54 Days 11 12 hr. min.

9. Birthplace BALTIMORE Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business GAS. & ELECTRIC CO.

12. Name ADAM GNAU

13. Birthplace BALTIMORE, Md.

14. Maiden Name BLANCH ROWE

15. Birthplace MUNKTON, Md.

16 (a) Informant MRS HELEN GNAU

(b) Address 5 SOUTH COLLINGTON AVE

17 (a) Burial (b) Date thereof 10-18-43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ST. STANISLAUS

Location Baltimore Md.

18 (a) Funeral director George A. Weber

(b) Address 705 S. Arundel St.

19 OCT 16 1943 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1943 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1943 to Oct 15 1943, and that I last saw him alive on Oct. 15 1943.

Immediate cause of death Congestive Heart Failure

Due to Hypertensive C-V Disease?

Due to

Other Conditions Probably Mesenteric Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Fusting

Address St. Joseph's Hosp Date signed 10-15-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-84305 G 09127 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 94a G 09127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Frankowiak Laufert (Frankline)
(b) If veteran name war (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27-1880
8. AGE: Years 63 Months 7 Days 16 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Theodore Ryczynski
13. Birthplace Poland
MOTHER 14. Maiden Name Antonniana ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (b) Date thereof Oct 18/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary.
Location Baltimore

18 (a) Funeral director Fred W. Ozyanski
(b) Address 1900 Eastern Ave.

19 (a) OCT 16 1943 (b)

20. DATE OF DEATH 10-13-43 5:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-43 to 10-13-43, and that I last saw her alive on 10-13-43.
Immediate cause of death Heart Attack
Due to Coronary Occlusion day
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Donald B. Hett M.D.
Address Baltimore City Health Department Date signed 10-13-43
Approved: Robert Lee Graham M.D.

PHYSICIAN Underline the cause to which death should be charged statistically.

Printed with printer's ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09128

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE MD.

(If outside city or town limits, write RURAL and give town)

(d) Street No 7 S. WOLFE ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Brother Augustine (Alfonse Schmidt)

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4 Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 15 1877

8. AGE:

66

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation LAY BROTHER

11. Industry or business ST. MICHAELS CHURCH

12. Name AUGUST SCHMIDT

13. Birthplace GERMANY

14. Maiden Name MARGARET BAUGH

15. Birthplace GERMANY

16 (a) Informant HENRY MESSIGREC.

(b) Address 7 S. WOLFE ST.

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 18/43

(month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Jailer INC.

(b) Address 403 S. WOLFE ST.

19 (a)

OCT 16 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1943 to Oct. 14 1943, and that I last saw him alive on Oct. 14 1943.

Immediate cause of death

Coronary Thrombosis

Duration 3 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Lusting

Address

St. Joseph's Hosp

Date signed 10-18-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09129
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3501 Copley Road
(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

3 (a) FULL NAME

William F. Seipel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or divorced.
married

6 (b) Name of husband or wife Elizabeth Walter

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 25, 1871

8. AGE: Years 72 Months 2 Days 18 If less than one day hr. min.

9. Birthplace Easton, Pa.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Lehigh Valley RR

12. Name Jacob Seipel

13. Birthplace Pa.

14. Maiden Name Sarah Bassett

15. Birthplace Pa.

16 (a) Informant Mrs. F. Murray Benson

(b) Address 3501 Copley Road

17 (a) Burial (b) Date thereof 10/16/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell's Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) OCT 16 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3501 Copley Road

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1943 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1939 to Oct 13 1943 and that I last saw him alive on Oct 13 1943.

Immediate cause of death

Myocarditis
Central hemiparesis & Paralysis

Due to Advanced
arteriosclerosis

Due to Hypertension

Other Conditions 1st. central hemiparesis & Paralysis
occurred prior to May 15 1939
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Walter E. Wildt

M. D.

2220 Garrison Blvd. Date signed

09130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09130
Registered No.PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos. or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)Street No. 436 E Cross St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-01-7799

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1880

8. AGE: Years Months Days If less than one day

63-6

hr. min.

9. Birthplace

Balt.

(Town, county, and state)

10. Usual Occupation Dis. Cutter11. Industry or business A.S. Printing - LithoFATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Delma Boyd(b) Address 436 E Cross St.17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Cedar Hill
Brooklyn Md18 (a) Funeral director William M. Moreck

(b) Address

19 (a) OCT 16 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 at 10:55 AM21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Fracture of
skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury October 14, 1943 7:30 AM(b) Where did injury occur? Cross & Lexington Sts.(c) Did injury occur at home, on farm, industrial place, in public
place? Public Place While at work? no(d) Means of injury struck by auto23. Signature Robert L. Graham M.D.Medical Examiner.
Signed October 14, 1943

09131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

09131

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave

(c) Hospital or institution:

Edgewood Nursing Home 27-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 2 mos

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No 6000 Bellona Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Elizabeth Kipp

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Elias J. Kipp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1857

8. AGE: Years 86 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Balto. Co. Md.

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

12. Name Henry Dany

13. Birthplace Germany

14. Maiden Name Charlotte

15. Birthplace Germany

16 (a) Informant Lt. Gen. W. E. Kipp

(b) Address 54 Duakirk Rd Rogers Forge

17 (a) Burial (b) Date thereof Oct 16 1943

(c) Cemetery or crematory Jerusalem Lutheran

Location Belair Road

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) OCT 16 1943

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13th 1943 6:20 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Oct 3 1943 to Oct 13 1943

and that I last saw her alive on Oct 13 1943

Immediate cause of death Chronic myxomatous

Due to

Due to

Other Conditions

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

Means of injury

23. Signature

Address 117 W. 25th St

Date of registration

117 W. 25th St

Date of registration

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09132
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1320 N. Central Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Emma Crowley (Crowley)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

John A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 17, 1899

8. AGE: Years

44

Months

7

Days

27

If less than one day

hr.

min.

9. Birthplace

Ind.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name William Gibson

MOTHER

13. Birthplace Va

14. Maiden Name Mary Brown

15. Birthplace Va

16 (a) Informant

Mary Dublin

(b) Address 1320 N. Central Ave.

17 (a)

Burial (Burial, cremation, or removal)

(b) Date thereof 10/18/43 (month) (day) (year)

(c) Cemetery or crematory

Douglas Memorial

Location Catonsville, Md.

18 (a) Funeral director

Joseph B. Lockard

(b) Address

1304 N. Central Ave.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balti.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1320 N. Central Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 14 1943 at 6:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1943 to Oct. 13 1943 and that I last saw her alive on Oct 19 43.

Immediate cause of death

Infar Pneumonia

Duration

2 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Ralph W. Beckley

Address

426 N. Gibson St. Date signed 10/15/43

G 09134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09134

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Norman Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 1942

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

David Daniels

13. Birthplace

Balto. Md.

14. Maiden Name

Thelma Clayton

15. Birthplace

Balto. Md.

16 (a) Informant

Thelma Daniels

(b) Address

1226 W. Lafayette Ave

17 (a)

Burial

(b) Date thereof

Oct 16-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

322 N. Howard St.

19 (a)

OCT 16 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1226 W. Lafayette Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 14

1943, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943, to Oct 14 1943, and that I last saw him alive on 19

Immediate cause of death

D.O.A.

Due to

Lobar Pneumonia

Duration

Approx. 1 week

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

10/14/43

of autopsy: Lobar Pneumonia (R. & L.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. B. Bayne

Address

Provident Hospital

M. D.

Date signed 10-15-43

Approved by J. Howard J. Williams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 09135

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09135
Registered No.

102

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 2 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ma* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1429 Jefferson St*
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Estella Hollins

3 (b) If veteran, name war

3 (c) Social Security Account
No. *217-09-1401*

4 sex *Female*
5. Color or race *Negro*

6 (a) Single, married, widowed, or divorced. *Married*

6 (b) Name of husband or wife. *Claude Hollis*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct. 5th 1897*

8. AGE: Years *46* Months *7* Days *7* hr. min.

9. Birthplace *Jaffrey S. C.*
(Town, county, and state)

10. Usual Occupation *Defense Worker*

11. Industry or business *Penn. R. R.*

12. Name *Shuman Proberry*

13. Birthplace *S. C.*

14. Maiden Name *S.*

15. Birthplace *S.*

16 (a) Informant *Rosetta Stanley*

(b) Address *1429 Jefferson St*

17 (a) *Burial* (b) Date thereof *Oct. 16 1948*
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory *mt calvary*
Location *Ar. A. Co. Md.*

18 (a) Funeral director *Bryson Thomas H. Knight*

(b) Address *721 McQuith St*

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams M.D. R. Howard Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 12 1948 10 9 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 11 1948* *Oct 12 1948* and that I last saw her alive on *Oct 12 1948*.

Immediate cause of death

Essential Hypertension
Due to *(Malignant Phase)*

Due to

Other Conditions *Uremia*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *G. H. B. Jones*

M. D.

Date signed *10-13-48*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 16 1948

G 09136

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09136
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

3 (a) FULL NAME

Baby Meeks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-29-43

8. AGE: Years Months Days

#

16

If less than one day

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John Meeks

13. Birthplace

14. Maiden Name

Elizabeth Jackson

15. Birthplace

16 (a) Informant

John Meeks

(b) Address

946 N. Arlington Ave

17 (a) Burial

(b) Date thereof

Oct. 16 1943

(Burial, cremation, or removal)

(month, day) (year)

(c) Cemetery or crematory

Arbutus Mem.

Location

18 (a) Funeral director

Mrs. Kate R. Williams

(b) Address

922 N. Schroeder St.

19 (a)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 906

Arlington Ave

(e) Citizen of foreign country?

(If rural, give location)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14

1943, at 230 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1943 to 10-14 1943 and that I last saw him alive on 10-14 1943.

Immediate cause of death Diarrhea + mal nutrition

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. B. Butler

Address

Provident Hospital

Date signed 10-16-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 16 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09137
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name. Wilbert Joseph Rejzek

13. Birthplace Baltimore, Maryland

14. Maiden Name Edna Katherine Petty

15. Birthplace Baltimore, Md.

16 (a) Informant Wilbert Joseph Rejzek

(b) Address 415 S. Bouldin St.

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore County, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1649 E. North Ave.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(If outside city or town limits, write RURAL, and give town)

(If rural give location)

(Yes or No)

MARY HELEN REJZEK

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-43 19 2:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1942, to Oct 15 1942, and that I last saw her alive on 10-15-42 19

Immediate cause of death Modulation failure

Due to An old chronic spine ligament

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-15-42

Major findings of operations as above.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

OCT 16 1943

VS 128

RAYMOND RANGLE

G 09138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09138
Registered No.

84103

YB

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

3 (a) FULL NAME

Effie V. Harms

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Herman Henry

Harms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1869

8. AGE: Years Months Days If less than one day
73 12 7 hr. min.

9. Birthplace Centreville, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name William Ross

13. Birthplace Easton, Maryland

14. Maiden Name Mary Bland

15. Birthplace Centreville, Maryland

16 (a) Informant J. Ross Prevost

(b) Address 4101 Buckingham Rd.

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1849 E. North Ave.

OCT 16 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Belto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1010 Abbot Court

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1943 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1943 to 10-15-1943, and that I last saw her alive on 10-15-1943.

Immediate cause of death

Terminal pneumonia

Due to

hypertensive disease

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Mott

Address RCH

Date signed 10/16/43

Duration

?

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

442325
G 09139BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09139
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Dorothy Lee Summers

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

JAMES

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.)

8-3-13

8. AGE:

Years 30

Months 2

Days 12

If less than one day

hr

min.

9. Birthplace

W. VA

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

NIM SWISHER

13. Birthplace

VA

14. Maiden Name

Betty Clayton

15. Birthplace

PA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Buried

(b) Date thereof

Oct 16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Fausmann

Location

W. Va.

18 (a) Funeral director

John Q. Mitchell & Sons

(b) Address

1900 Antero Place

19 (a)

(b)

Huntington Williams, M.D.

OCT 16 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

W. VA

(b) County

MARION

(c) City or town

CATAWBA

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 15

1943, at 10:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1943, to Oct 15 1943, and that I last saw her alive on Oct 15 1943.

Immediate cause of death

Pulmonary Embolism

Duration

11 hrs.

Due to

Post-operative -
Hysterectomy, bilat.

Due to

Carcinoma, bladder

2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Oct. 11, 1943

Major findings of operation:

Carcinoma

bladder

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Roger B. Scott

Address

Johns Hopkins Hosp.

Date signed Oct 16, 1943

PRINTED WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

99140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **Wyman Park Drive & 31st St.**

(c) Hospital or institution:
U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) **1 day**

(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

3 (a) FULL NAME

WM. HENRY LATHE, JR.

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No. **--**

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. **Married**

6 (b) Name of husband or wife **Jennie Elisabeth Hadaway**

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) **Feb. 2, 1894**

8. AGE: Years Months Days If less than one day
49 8 12 hr. min.

9. Birthplace **Baltimore, Md.**

(Town, county, and state)

10. Usual Occupation **None**

11. Industry or business

12. Name **Walter R. Lathe**

13. Birthplace **Md.**

14. Maiden Name **Eula Clayton**

15. Birthplace **Md.**

16 (a) Informant **Records, U.S. Marine Hospital**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10-18-43**

(Burial, cremation, or removal)

(c) Cemetery or crematorium **Baltimore National**

Location **Freshwater Rd.**

18 (a) Funeral director **A. Lee Odes**

(b) Address **444 York Rd.**

OCT 17 1943

(Date rec'd by registrar)

William Williams

10/18/43

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.**

(b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **408 S. Calhoun Street**

(If rural give location)

(e) Citizen of foreign country? **No**

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **October 14, 1943, 10:20 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 13, 1943, to Oct. 14, 1943** and that I last saw him alive on **Oct. 14, 1943**

Immediate cause of death **Lobar pneumonia, left lung**

Duration
Unk.

Due to

Due to

Other Conditions **Congenital Polycystic disease both kidneys**

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operation:

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature **L. S. Barn**

Address **Baltimore, Md.**

Date signed **10/18/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09141
1216

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

President Hwy.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

14
2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John H. Brown

3 (b) If veteran, name

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

A A

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Ornel Phoebe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 15, 1865

8. AGE:

Years

Months

Days

If less than one day

78

1865

March

15

29

hr.

min.

9. Birthplace

Calvert Co. Md.

(Town, county, and state)

10. Usual Occupation

none Farmer

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

Rachel Randall

15. Birthplace

Md.

16 (a) Informant

John E. Brown

(b) Address

Middle River Md.

17 (a)

Burial

(b) Date thereof

Oct. 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stephen Cemetery

Location

Middle River Md.

18 (a) Funeral director

Mrs. Robert A. Edmister & Son

(b) Address

1129 St. Pauline St.

OCT 17 1943

(b)

John H. Brown

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

E. Bay

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 17

19

43

21. I certify that death occurred on the date above stated; that I attended

deceased from 10-11-1943, to 10-14-1943

and that I last saw him alive on 10-13-1943

Immediate cause of death

Due to

Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify exact place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

ROBERT L. JACKSON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		61	6-09142
CERTIFICATE OF DEATH		61	Registered No.
1. PLACE OF DEATH:			
(a) Baltimore City, Maryland			
(b) Street address <i>Monument + Rutland</i>			
(c) Hospital or institution: <i>Sinai Hospital</i>			
(d) Length of stay in hospital or inst. (yrs., mos., or days) <i>7</i>			
(e) Length of stay in Baltimore (yrs., mos., or days)			
2. USUAL RESIDENCE OF DECEASED:			
(a) State <i>Md</i> (b) County <i>Baltimore</i>			
(c) City or town <i>Middle River</i> (If outside city or town limits, write RURAL and give town)			
(d) Street No. <i>Wilson Pt Road Apt B100</i> (If rural give location)			
(e) Citizen of foreign country? (Yes or No) If yes, name country			
3 (a) FULL NAME <i>Martha Gillespie</i>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <i>F</i>	5. Color or race <i>Wh</i>	6 (a) Single, married, widowed, or divorced <i>Widowed</i>	
6 (b) Name of husband or wife <i>John Gillespie</i>			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <i>8/3/1884</i> <i>1884</i>			
8. AGE: Years <i>59</i>	Months <i>2</i>	Days <i>13</i>	If less than one day hr. min.
9. Birthplace <i>Buffalo, N.Y.</i> (Town, county, and state)			
10. Usual Occupation <i>Practical Nurse</i>			
11. Industry or business			
12. Name <i>Unknown</i> <i>Wm. Ziegler</i>			
13. Birthplace <i>Germany</i>			
14. Maiden Name <i>Unknown</i>			
15. Birthplace <i>Germany</i>			
16 (a) Informant <i>Hospital Records</i>			
(b) Address			
17 (a) <i>Burial</i> (b) Date thereof <i>10/10/43</i> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory			
Location <i>Youngstown Ohio</i>			
18 (a) Funeral director <i>William J. Dickner + Son</i>			
(b) Address <i>North + Pennsylvania Ave</i>			
19 (a) <i>17</i> (b) <i>Huntington Williams, Md</i> (Date rec'd by registrar)			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <i>October 16 1943</i> at <i>4:08 P.M.</i>			
21. I certify that death occurred on the date above stated; that I attended deceased from <i>10-7 1943</i> to <i>10-16 1943</i> , and that I last saw her alive on <i>10-15 1943</i> .			
Immediate cause of death <i>Cerebral hemorrhage</i>			
Due to <i>Hypertensive vascular disease</i>			
Due to			
Other Conditions <i>Arteriosclerosis</i> <i>Diabetes Mellitus</i> (Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations <i>Cerebral hemorrhage</i>			
of autopsy: <i>Cerebral hemorrhage</i>			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(e) Means of injury			
23. Signature <i>Herbert R. Jacobs</i>			
Address <i>Sinai Hospital</i> Date signed <i>10/16/43</i>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09143
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 23rd St.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD.

(b) County Baltimore

(c) City or town Ruxton

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John William Ford

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NO

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1864

8. AGE: Years Months Days If less than one day

79

0

9

hr.

min.

9. Birthplace

Louisiana

10. Usual Occupation

Retired

11. Industry or business

12. Name

Patrick Ford

13. Birthplace

Ireland

14. Maiden Name

Bridgett Bennett

15. Birthplace

Ireland

16 (a) Informant

Mr. H. P. McNealy

(b) Address

902 Keyser Bldg.

17 (a) Removal

(b) Date thereof 10/16/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Patrick's

Location

New Orleans, La.

18 (a) Funeral director

Wm. J. Tucker & Son

(b) Address

Baltimore, Md.

19 (a) Date rec'd by registrar

Oct 17 1943

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1943, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1943, to Oct. 15 1943, and that I last saw him alive on Oct. 15 1943.

Immediate cause of death Cardiac and Respiratory failure

Due to Arteriosclerotic heart disease

Due to Arteriosclerosis

Other Conditions Residual

hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Mungatunga Jr.

M. D.

Address 332 E. University Pk. Date signed 10/15/43

Duration

243

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARYLAND STATE DEPARTMENT OF HEALTH

2431 N. Charles St., Baltimore

CERTIFICATE OF DEATH

937

G 09144

Reg. Dist. No.

1. PLACE OF DEATH:

Home
City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town.)
How long in above place of death? Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Home
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town.)
Street No. 3100 Maple Ave.
(If rural, give LOCATION)
2. (c) If veteran, name war

3. (a) FULL NAME

Arie Ellen Berger

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. Single, married, widowed, or divorced Widow

7. (b) Name of husband or wife Jessie Berger 8. (c) If alive, give age years

9. Birth date of deceased (mo., day, yr.) June 9, 1871

10. AGE: Years 72 Months 4 Days 8 If less than one day hrs. min.

11. Birthplace Hagerstown, P.R. 2 Wash Co., Md.
(Town, county, and state)

12. Usual occupation Housewife

13. Industry or business Home

14. Name Joseph Berger

15. Birthplace near Hagerstown, Md.

16. Maiden name Elizabeth Rumrill

17. Birthplace no record

18. Informant Miss Grace Berger

Address 3100 Maple Ave. Balt. Md.

19. Burial Prices Church Date thereof Oct. 19, 43
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Prices Church

Location near Hagerstown, Pa.

20. Funeral director Albert M. Hoyer

Address Hagerstown, Md.

17 1943 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 19 43 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10th 19 43 to Oct 17th 19 43 and that I last saw him alive on Oct 16th 19 43

Immediate cause of death Chronic Valvular Heart Disease

Due to Chronic Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Weinberg

Address 2735 Park Heights Ave Date signed 10/17-43

G 09145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 448 N. Patterson Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Josephine Becola Lazzaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife. Angelo Lazzaro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1853

8. AGE: Years Months Days If less than one day

89 90 9 23 hr. min.

9. Birthplace Italy

10. Usual Occupation Housewife

11. Industry or business

12. Name Vincent Becola

13. Birthplace Italy

14. Maiden Name Margaret Di Cola

15. Birthplace Italy

16 (a) Informant Don Louis Lazzaro

(b) Address 448 N. Patterson Park Ave

17 (a) Burial (b) Date thereof Oct 19 43

(c) Cemetery or crematory St. Stanislaus

18 (a) Funeral director Frank V. Lepitone

(b) Address 2818 E. Baltimore St

19 (a) Date of death Oct 17 1943

(b) Signature of physician Michael J. Danach

(c) Address 3530 E. Baltimore St

(d) Date signed 10/16/43

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Balto. City

(d) Street No. 448 N. Patterson Park Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1943. at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1943, to Oct 15 1943, and that I last saw her alive on Oct 15 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Michael J. Danach M.D.

Address 3530 E. Baltimore St Date signed 10/16/43

Duration

4 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address Calvert and Santiago

(c) Hospital or institution:

Mary Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 535 S. Calhoun St.
(If rural give location)(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME

Howard Edward Whal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or divorced.6 (b) Name of husband or wife Marie A. Whal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-18908. AGE: Years 53 Months 52 Days 9 If less than one day
4 hr. 4 min.9. Birthplace York, Pa.
(Town, county, and state)10. Usual Occupation Unemployed

11. Industry or business

12. Name James Albin Whal13. Birthplace Towson, Md.14. Maiden Name Sarah Ellen Carr15. Birthplace York, Pa.16 (a) Informant Mary A. Whal(b) Address 535 S. Calhoun St.17 (a) Burial (b) Date thereof 10-18-43
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory LovansLocation Baltimore, Md.18 (a) Funeral director Sam & A. Fisher(b) Address Fulton & Fay sts.19 (a) 17 1943 (b) Franklin Williams, M.D.
Date of registration Registrar

VB 158

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1943 at 5 AM21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1943 to 10-15-1943, and that I last saw him alive on 10-15-1943.

Immediate cause of death

Baetic CancerDuration
2 yrs.

Due to

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature William C. LaneAddress Mary Hospital Date signed 10-15-43Physician
Lane
PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

44 2213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 09147

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

3 (a) FULL NAME

Myer D. Poland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-7-77

8. AGE: Years

Months

Days

If less than one day

56

3

6

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Paper Box Business

11. Industry or business

12. Name

Poland

13. Birthplace

Russia

14. Maiden Name

?

15. Birthplace

Russia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct 17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hollow Road

Location

Hamilton Ave

18 (a) Funeral director

Sol Lewinson, Bur

(b) Address

1124-26 W North Ave

OCT 17 1943

(b)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3815 Park Heights

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 13

1943 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1943 to Oct 13 1943 and that I last saw him alive on Oct 13 1943.

Immediate cause of death Myocardial infarction due to thrombosis of coronary artery -

Due to arterio sclerotic heart disease

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E.S. Cross Jr

Address J. H. H.

Date signed 10-13-43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age of the deceased is especially important. Physicians: please write the causes of death clearly and legibly.

G 09148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09148

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 236 S. Ann St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

John Walter Sedor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1943

8. AGE: Years Months Days

5

If less than one day

hr.

min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Walter Valentius Sedor

13. Birthplace Buffalo, N. Y.

14. Maiden Name Clara Bealab's Garg

15. Birthplace Baltimore Md

16 (a) Informant Mrs. Clara Sedor

(b) Address 236 S. Ann St.

17 (a) Burial (b) Date thereof 10-18-43 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore Md.

18 (a) Funeral director George A. Weber

(b) Address 705 S. Ann St.

(c) Address Huntington Hill, Md.

19 (a) Date of registration

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1943, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11, 1943, to Oct 16, 1943, and that I last saw him alive on Oct 16, 1943.

Immediate cause of death

Respiratory asphyxiation. Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabella Harrison

Address Church Home Hospital, Date signed 10-18-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09149

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1921 E. Preston street

(c) Hospital or institution: --

(d) Length of stay in hospital or inst. (yrs., mos., or days) --

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1921 E. Preston street

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

FREDERICK J. SNOWMAN

3 (b) If veteran, name war
NO3 (c) Social Security Account
No. 213-09-13204. Sex
Male5. Color or race
white6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Margaret Snowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1874

8. AGE: Years Months Days If less than one day
68 10 29 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired- Clerk

11. Industry or business

12. Name Frederick J. Snowman

13. Birthplace Baltimore, Md.

14. Maiden Name Josephine Krieger

15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mildred Snowman

(b) Address 1921 E. Preston street

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 15 1943 at M

21. I certify that death occurred on the date above stated; that I attended
deceased from March 1942 to Oct 15, 1943,
and that I last saw him alive on Oct 14, 1943.

Immediate cause of death Bronchitis pneumonia

Duration

3 days

Due to Lung Abscess - right
upper lobe

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Helen I. Lagimodiere

Address 1445 N. Gay St Date signed 10/15/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 17 1943
VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09150

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 725 E. Preston street
(c) Hospital or institution: ---
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) ---

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 E. Preston street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY E. SANDMAN

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. Oct. 15, 1878

8. AGE: Years

64

Months

11

Days

29

If less than one day

hr.

min.

9. Birthplace

Balto. Co. Md.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER
MOTHER

12. Name Bernard Sandman

13. Birthplace Germany

14. Maiden Name Mary T. Werenker

15. Birthplace Germany

16 (a) Informant Miss Anna M. Sandman

(b) Address 725 E. Preston street

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/18/43

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral Director

(b) Address

19 (a)

(Date of death)

OCT 17 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1943 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1943 to Oct 14 1943 and that I last saw her alive on Oct 13 1943

Immediate cause of death Coronary Occlusion

Arteriosclerotic Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Israel Rosen

M. D.

Address 2413 E. Monument St

80/15/43

G 09151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09151

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2027 W Baitch

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

3 (a) FULL NAME

John R. Brown

3 (b) If veteran, name war

non

3 (c) Social Security Account

No. non

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Married

6 (b) Name of husband or wife Louis Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16 - 1955

8. AGE: Years Months Days If less than one day

88 1 29 hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Bricklayer (Retired)

11. Industry or business

12. Name John M. Brown

13. Birthplace Balto - Md

14. Maiden Name Sophia C. Batezel

15. Birthplace Balto - Md

16 (a) Informant Mrs Sophia C. Brown

(b) Address 2027 W Baitch St

17 (a) Burial (b) Date thereof Oct. 11 - 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Rev. L. Beyer Jr

(b) Address 1512 Hollis St

19 (a) Date of registration 12-1943

(b) Registrar H. W. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 2027 W Baitch St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1943 at 1:30 PM

21. I certify that death occurred on the date above stated that I attended deceased from 10/12 1943 to 10/15 1943

and that I last saw him alive on 10/15/43

Immediate cause of death

Cerebral thrombosis 4 hrs

Due to Cerebral thrombosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas A. Baker

Address 2145 W Baitch St

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09152

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 931 S. Hanover St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

John H. Hoyer

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 75 ? Months Days If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant John J. Hoyer

(b) Address 931 S. Hanover St.

17 (a) Burial (b) Date thereof 10-18-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cemetery

Location A. A. Co. Md.

18 (a) Funeral director Flippin & Flippin

(b) Address 1476 High St.

19 (a) H. William Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 931 S. Hanover St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16/43 19 43 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12/43 to Oct. 16/43 and that I last saw him alive on Oct. 11/43.

Immediate cause of death

Arterio-Sclerosis.

Duration

Unknown.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Henry H. Hoyer

Address 933 Trautman

WALDSCHNIDT

OCT 17 1943

G 09153

BALTIMORE CITY HEALTH DEPARTMENT

G 09153

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Louis Baker

3 (b) If veteran, name war

3 (c) Social Security Account

No. 217-07-3932

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

53

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

12. Name

Tobias Baker

13. Birthplace

Russia

14. Maiden Name

Sarah

15. Birthplace

Russia

16 (a) Informant

Family

(b) Address

17 (a)

Burial

(b) Date thereof

10-17-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore Hebrew

Location

Baltimore Md.

18 (a) Funeral director

Jank Lewis Inc

(b) Address

1439 E. Baltimore St

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3505 Fairview Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 15

1943

5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1943, to Oct 15 1943, and that I last saw him alive on May 9 1943.

Immediate cause of death

Coronary Occlusion

Due to

Chronic Myocarditis
Sty potensin; Obesity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Michael A. Thomas

Address

2360 Euter place

Date signed

M. D.

10-6-43

Approved by Dr. M. J. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 17 1943

VB 150

G 09154

440090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09154

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3108 Charles Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Dr. Sam H. Homel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Odesa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-17-11

8. AGE:

Years

Months

Days

If less than one day

32126

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Dentist

11. Industry or business

12. Name

Frank Homel

13. Birthplace

Russia

14. Maiden Name

Bessie Melnickoff

15. Birthplace

Russia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10-17-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or mortuary

St. John's

Location

St. John's

18 (a) Funeral director

Jack Lewis

(b) Address

1439 E. Baltimore StHuntington Williams, Md19 1-7-1943

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1943 at 7:20 P21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1943 to Oct 13 1943, and that I last saw him alive on Oct 13 1943.

Immediate cause of death

Cerebral edema

Duration

48 hrsDue to Neoplasiasubacute bacterial endocarditis & valve

Due to

Rheumatic heart disease?Other Conditions mitral stenosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. S. Cross Jr.

M. D.

Address J. H. H.Date signed 10-14-43

G 09155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09155
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2808 Berwick Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Jacob Getzer

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Jeanne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1887

8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

Russey

(Town, county, and state)

10. Usual Occupation

Real Estate

11. Industry or business

FATHER
MOTHER

12. Name

Solomon Getzer

13. Birthplace

Russey

14. Maiden Name

Katz

15. Birthplace

Russey

16 (a) Informant

(b) Address

Wife

17 (a)

Burial

(b) Date thereof

10-17-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Southern Ave.

Location

Southern Ave.

18 (a) Funeral director

J. L. Lewis

(b) Address

1439 E. Baltimore

19 (a)

17 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-13

1943

at 9:55 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-13-43

7 A 27/7

(b) Where did injury occur?

Anger Rd - Berwick Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work? No

(d) Means of injury

Passenger struck by automobile

23. Signature

Thomas J. Wolden

M.D.

Date signed 10-13-43

Medical Examiner.

G 09156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09156

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/11/69

19 43

at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/69 19 43 to 10/11/69 19 43, and that I last saw him alive on 10/11/69 19 43.

Immediate cause of death: Myocardial Infarction

Duration

Due to

Coronary Thrombosis

Due to

Hypertension & G.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. D. Hamilton

M. D.

Address

Sinai Hospital

Date signed 10/11/69

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09157

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b)

(Date recorded by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

OCT 17 1943

Huntington Williams, M.D.

GLUCK

G 09158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09158

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 1943

VS 114

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 16

1943 at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1943 to Oct 16 1943, and that I last saw him alive on Oct 16 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

NEVER WRITE IN BLANK SPACES. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09159

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1253 Battery Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 1253 Battery Ave.

(If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore, Md.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Aramintha Parsons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

W.

6 (b) Name of husband or wife Alfred Parsons.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1891

8. AGE: Years Months Days If less than one day
41 " 26 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

James Williams

13. Birthplace

Md.

14. Maiden Name

Anna ?

15. Birthplace

Md.

16 (a) Informant

Family

(b) Address

1253 Battery Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 10/18/43

(month) (day) (year)

(c) Cemetery or crematory

Grond Ridge

Location

Pikesville, Md.

18 (a) Funeral director

James L. McCully

(b) Address

1253 Battery Ave.

19 (a) 17 1943

(Date received by Registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1943 at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1942, to Oct. 14, 1943, and that I last saw him alive on Oct. 14, 1943.

Immediate cause of death

Arteriosclerosis

Due to

Arteriosclerosis Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N.P. Friedman, M.D.

Address 1319 Light St. Date signed 10/15/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09160
T.N

79591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09160
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave**
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) **8 months**
(e) Length of stay in Baltimore (yrs., mos., or days) **2 yrs**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1006 W. Lenvale St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Arthur Adams

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
C6 (a) Single, married, widowed, or
divorced. **Married**6 (b) Name of husband or wife **Hazel Adams**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 19, 1918**8. AGE: Years Months Days If less than one day
25 3 27 26 hr. min.9. Birthplace **Florida**
(Town, county, and state)10. Usual Occupation **Cook**

11. Industry or business

12. Name **John Adams**13. Birthplace **Fla.**14. Maiden Name **Gertrude Sander**15. Birthplace **Kla.**16 (a) Informant **Baltimore City Hospitals**(b) Address **4940 Eastern Ave (Records)**17 (a) **Serial** (b) Date thereof **Oct. 19, 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory
Location **Arboretum Mem. Cem.**18 (a) Funeral director **Mr. George W. Halland**(b) Address **1631 Duval St. S.W.**19 (a) **OCT 17 1943** (b) **Huntington Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **10/15 1943** at **6:15 P.M.**21. I certify that death occurred on the date above stated; that I attend-
ed deceased from **7/1 1943** to **10/15 1943**,
and that I last saw him alive on **10/15 1943**.

Immediate cause of death

Pulmonary TBC

Duration

13 mo.

Due to

Due to

Other Conditions

**Syphilis;
TBC Laryngitis**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Searman

Address

BCH

Date signed

M.D.

10/16

G 09161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09161

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 709 Mader Street

(If rural give location)

(e) If foreign born, how long in U. S. A?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 14 1943, at 5 a. M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Oct 1943 to Oct 14 1943.

and that I last saw her alive on Oct 13 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 825 N. Fremont Date signed 10/14/43

Duration

Diabetes Mellitus 5 yrs +

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

OCT 17 1943

Huntington

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09162
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home + Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Anne Arundel

(c) City or town

Harwood

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Richard Lee Hardesty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/10/1871

8. AGE: Years

72

Months

0

Days

4

If less than one day

hr.

min.

9. Birthplace

Galesville Md.

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name Mr. Richard Hardesty

13. Birthplace Anne Arundel Co Md

14. Maiden Name Audrey Wood

15. Birthplace P. O. Co Md

16 (a) Informant

Claude Wood

(b) Address

Sudley, Md.

17 (a) Burial

(b) Date thereof Oct 19/43

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

Quaker

Location

Galesville Md

18 (a) Funeral director

T. A. Hardesty & Son

(b) Address

Galesville Md

19 (a)

(b)

(Date rec'd by registrar)

Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1943 at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - P. 1943 to 10 - 17 1943, and that I last saw him alive on 10 - 17 1943.

Immediate cause of death

Carcinoma of Tongue with Metastasis To Neck

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 12 1943

Major findings of operations: as above

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature John M. Buller Jr

M. D.

Address Church Home + Hosp

Date signed 10 - 17 - 43

Quaker + Fairmont

G 09163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09163

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Greenpring & Belvedere*

(c) Hospital or institution:

Hebrew Home for God & Sufferers(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 yrs.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Greenpring & Belvedere*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Yetta Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1864

8. AGE: Years

Months

Days

If less than one day

79

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Yetta

13. Birthplace

Russia

14. Maiden Name

Yetta

15. Birthplace

Russia

16 (a) Informant

Wp. Records

(b) Address

17 (a) *Burial*(b) Date thereof *10-17-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Windsor Tree Road

Location

18 (a) Funeral director

Jace Reins Inc

(b) Address

*1139 E. Balto. St*19 (a) *17 1943*d by registrar *Washington Williams, M.D.*

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/13* 19*43* at *4:20 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *6/10/1939* to *10/13/1943*, and that I last saw her alive on *10/13/1943*.

Immediate cause of death

Coronary Thrombosis

Due to

Due to *Generalized Arterio Sclerosis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edmund Reins

M. D.

Address

Reverdale

Date signed

G 09164

BALTIMORE CITY HEALTH DEPARTMENT

G 09164

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Street address 1717 Jefferson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 Jefferson St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME Louise Williams

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

Col.

6 (a) Single, married, widowed, or

divorced. Widowed

6 (b) Name of husband or wife Samuel Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1881

8. AGE: Years Months Days If less than one day

62

1

26

hr.

min.

9. Birthplace Petersburg, Va.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Frank Clayborn

13. Birthplace Va.

14. Maiden Name Sarah ?

15. Birthplace ?

16 (a) Informant Leatha Patton

(b) Address 1002 N. Eden St.

17 (a) Burial (b) Date thereof 10/17/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave.

(c) Date rec'd by registrar 10/17/43

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-43 19 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-18-1943 to 10-17-1943
and that I last saw him alive on 10-12-43 19

Immediate cause of death

Cordis - Heart Failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 312 E 23rd St

Date signed 10-16-43

Duration

?

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 09165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09165

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) J.D.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 W. Pratt St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John Smith Mullins

3 (b) If veteran, name war

3 (c) Social Security Account

No. 400-01-4765

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Egnell Wheeler

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr) March 18, 1884

8. AGE: Years Months Days If less than one day

59

6

26

hr.

min.

9. Birthplace Cannell City, Kentucky

(Town, county, and state)

10. Usual Occupation Miner & Baker's Helper

11. Industry or business Mine & Bakery

12. Name J. S. Mullins

13. Birthplace Wisc. Ia.

14. Maiden Name Mary E. Francis

15. Birthplace Morgan, Kentucky

16 (a) Informant Mrs. Egnell Mullins

(b) Address 1204 W. Pratt St.

17 (a) Burial (b) Date thereof 10/18/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Pleasant

Location Frederick, Md.

18 (a) Funeral director J. S. Williams

(b) Address 1600 N. Hollins St.

(c) City, State, and Zip Code

Huntington, W. Va. 25701

19. Date of death

October 14, 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1943, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic rheumatic endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Medical Examiner.

Date signed October 14, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

909166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

909166

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4305 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4305 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Leonard Bruce Andersen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Anna Blum Andersen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1878

8. AGE:

Years

Months

Days

If less than one day

66

8

1

hr.

min.

9. Birthplace

Baltimore Ind.
(Town, county, and state)

10. Usual Occupation

Grocer

11. Industry or business

FATHER

12. Name

Harry A. Andersen

13. Birthplace

Baltimore Ind.

MOTHER

14. Maiden Name

Mary Miller

15. Birthplace

Baltimore Ind.

16 (a) Informant

Mrs. Margaret W. Andersen

(b) Address

4305 Garrison Blvd.

17 (a)

Burial

(b) Date thereof

Oct. 12 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

David Ridge Farm

Location

Baltimore

18 (a) Funeral director

James L. Snyder

(b) Address

1600 W. North Ave.

19 (a)

OCT 18 1943

(b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 15 - 1943. at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 - 1943 to Oct 15 - 1943, and that I last saw him alive on Oct 14 - 1943.

Immediate cause of death

Coronary occlusion

Due to arteriosclerosis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

James L. Snyder

M. D.

Address

2220 Garrison Blvd.

Date signed

OCT 16 1943

G 09167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. G 09167

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va.

(b) County

(c) City or town Norfolk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 439 Sherwood Place

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George

Tegg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Margaret F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1872

8. AGE: Years Months Days If less than one day

71

5

27

hr.

min.

9. Birthplace Rochester N. Y.

(Town, county, and state)

10. Usual Occupation

retired

11. Industry or business

12. Name George Tegg.

13. Birthplace England.

14. Maiden Name Kate Renate

15. Birthplace Alabama

16 (a) Informant C. Herbert Tegg

(b) Address Norfolk Va.

17 (a) Removal (b) Date thereof Oct 17, 43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Norfolk Va.

18 (a) Funeral director William Cook

(b) Address 1217 St Paul St

19 (a) (b) Huntington Williams, M.D.

(Date of death) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1943, at 10 AM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Laceration of

brain

Due to fall down stairs

Other Conditions arteriosclerotic cardio-

vascular disease.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury October 9 1943 11:30 AM

(b) Where did injury occur? 207 E. 40th St N.Y.C.

(c) Did injury occur at home, on farm, industrial place, in public

place? Hotel While at work? yes

(d) Means of injury Fall down stairs

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed Oct. 17 1943

See instructions on page 1 of this certificate. Please write the cause of death clearly and legibly.

OCT 18 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30e G 09168
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

59 8 15 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09169
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1321 Madison Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James Albert Hardy

3 (b) If veteran, name war

3 (c) Social Security Account

No 217-05-2366

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband as wife Emma Hardy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1882

8. AGE: Years Months Days If less than one day

60 50 11 8 22 hr. min.

9. Birthplace Baltimore

(City, county, and state)

10. Usual Occupation Porter

11. Industry or business General Baking Co

12. Name Unknown

13. Birthplace

14. Maiden Name Isabella Hardy

15. Birthplace Ind

16 (a) Informant Emma Hardy

(b) Address 1321 Madison Ave

17 (a) Burial (b) Date thereof Oct 18-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Calvary

Location a a Co

18 (a) Funeral director Sam'l N Chase Hon

(b) Address 638 N. Calmar St

19 (a) OCT 1 (b) Huntington Williams

(Date of registration) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 1321 Madison Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1943 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended

deceased from Oct 2 1943 to Oct 14 1943.

and that I last saw him alive on Oct 14 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Paralysis

Due to

Other Conditions Age

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature James C. O'Keefe

M. D.

Address 1016 E. Sharp St

Date signed 10-16-43

G 09170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09170
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 425 N. Washington St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs3 (a) FULL NAME Edith L. Gurney

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex Female5. Color or race W6 (a) Single, married, widowed, or divorced Married6 (b) Name of husband or wife Alfred Gurney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 13, 1895

8. AGE:

Years 48Months 6Days 2

If less than one day

hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
MOTHER12. Name Geo Prediger13. Birthplace Germany14. Maiden Name Don't know15. Birthplace Germany16 (a) Informant Loretta Kelly(b) Address 3141 Ravenwood Ave17 (a) Burial(b) Date thereof Oct 18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore City

Location

18 (a) Funeral director Ulrich Funeral Home(b) Address 2004-8. Orleans19 (a) Edith L. Gurney

(Date rec'd by)

Washington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD(b) County Balt(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 425 N. Washington St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1943 at 6 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1942 to Oct 15 1943 and that I last saw her alive on October 14 1943Immediate cause of death Carcinoma of uterusDue to metastasis to rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(a) Means of injury

23. Signature Joseph LinderAddress 1701 E. Fayette StDate signed 10/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 09171

CERTIFICATE OF DEATH

G 09171

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Chilham Road Ward 597)Registered No. _____
(If death occurred in
a hospital or institution,
give its NAME instead
of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Josephine Bushman(a) Residence: No. 2200 Chilham Road Ward _____
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed,
or Divorced (write the word) Widowed6a. If married, widowed, or divorced
husband or
(or) WIFE of John H. Bushman6. DATE OF BIRTH (month, day, year) July 12, 18477. AGE Years 96 Months 3 Days 4 If LESS than
1 day, hrs. or min.8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc. At Home9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc. Self10. Date deceased last worked at
this occupation (month and
year) 11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town) Guthsburg Pa.
(State or country)13. NAME John Norbeck14. BIRTHPLACE (city or town) Pa.
(State or country)15. MAIDEN NAME Mary Hause16. BIRTHPLACE (city or town) Pa.
(State or country)17. INFORMANT Samuel Bushman
(Address) Dorson Md18. BURIAL, CREMATION, OR REMOVAL
Place New Cathedral Date 10/19, 194319. UNDERTAKER William Cook Inc
(Address) 1217 St. Paul St.20. Funerary William Cook Inc

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct-16, 194322. I HEREBY CERTIFY, That I attended deceased from
May 19, 1942 to Oct 15, 1943I last saw her alive on Oct 15, 1943 death is said
to have occurred on the date stated above, at 12 NoonThe principal cause of death and related causes of
importance were as follows:Arteriosclerosis
Senility

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the
following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public
place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of
deceased? If so, specify(Signed) Samuel H. Culbreth M. D.(Address) 5611 Riverside Rd

OCCUPATION is very important. See instructions on back of certificate.

G 09172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09172

Registered No.

13 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette St

(c) Hospital or institution:

Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

3 (a) FULL NAME

Percy Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Irene M. Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-19-1900

8. AGE: Years Months Days If less than one day

43 8 26 5 hr. min.

9. Birthplace England

(Town, county, and state)

10. Usual Occupation Shipfitter

11. Industry or business

12. Name Henry W. F. Ford

13. Birthplace England

14. Maiden Name Kate Wren

15. Birthplace England

16 (a) Informant Mrs Irene M. Ford

(b) Address 4724 Patrick Henry Drive

17 (a) Burial (b) Date thereof 12-8-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (b) Registered by Registrar

Huntington Williams, M.D.

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Anne Arundel

(c) City or town Baltimore Brooklyn

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4724 Patrick Henry Drive

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1943 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1943, to 10-14 1943,

and that I last saw him alive on 10-14 1943.

Immediate cause of death

Tuberculosis pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: on above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Samuel Rubin

M. D.

Address 203 Potomac Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09173
442537

VERA DOLMAT
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9/15/43 G 09173
Registered No. 1246

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address (c) Hospital or institution: JOHNS HOPKINS HOSPITAL (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 (e) Length of stay in Baltimore (yrs., mos., or days)				2. USUAL RESIDENCE OF DECEASED: (a) State Md (b) County (c) City or town Baltimore (If outside city or town limits, write RURAL and give town) (d) Street No. 120 S Eden (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country			
3 (a) FULL NAME MARY SISKON (Vera Dolmat)				3 (c) Social Security Account No.			
4. Sex Female		5. Color or race White		6 (a) Single, married, widowed, or divorced. WIDOW			
6 (b) Name of husband or wife 213-16-9175				6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) 09-15-96							
8. AGE: Years 47		Months -		Days 29 If less than one day hr. min.			
9. Birthplace Poland (Town, county, and state)							
10. Usual Occupation Seamstress							
11. Industry or business East Dept.							
12. Name Anthony Sisko							
13. Birthplace Poland							
14. Maiden Name Agatha VERA MALCHMOSKI							
15. Birthplace Poland							
16 (a) Informant Records							
(b) Address JOHNS HOPKINS HOSPITAL							
17 (a) Burial (Burial, cremation, or removal)				(b) Date thereof Oct. 18-1943 (month) (day) (year)			
(c) Cemetery or crematory Holy Redeemer							
Location Belair Rd. Balt. Md.							
18 (a) Funeral director Frank Della Hore							
(b) Address 52 N. Morley St.							
19 OCT 18 1943							

20. DATE OF DEATH Oct 14 1943, at 7:25 P	
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1943 to Oct 14 1943 and that I last saw her alive on Oct 14 1943.	
Immediate cause of death Cirrhosis of liver	
Due to	Duration
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations:	
of autopsy:	
22. If death was due to external causes, fill in the following:	
(a) Accident, suicide, or homicide	
(b) Date of occurrence	at M
(c) Where did injury occur? (City or town) (County) (State)	
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?	
(e) Means of injury	
23. Signature John R. Birmingham	
Address J H H	Date signed 10-15

G 09174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09174

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2707 Parkwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2707 Parkwood Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

EMILY B. DOBYNS

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife William A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1865

8. AGE: Years Months Days If less than one day
78 4 27 hr. min.9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Lorenzo D. Shockey

13. Birthplace Carroll Co., Md.

14. Maiden Name Mary J. Heaps

15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. Wm. A. Dobyns

(b) Address 2707 Parkwood Ave.

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (b)

(Date of death by registrar) Registrar

vs OCT 18 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1943, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1943, to Oct. 14, 1943, and that I last saw her alive on Oct. 14, 1943.

Immediate cause of death

Myocarditis (chronic)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Eugene L. Parnes

Address 515 Overy Lane

M. D. Date signed Oct. 16, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09175
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Calvert & Sanatoga*
(c) Hospital or institution *Mary Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *11 1/2 months*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3615 Woodbine Avenue*
(If rural give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN CHARLES LISCIAIRO, JUNIOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *October 24th, 1942*

8. AGE: Years Months Days If less than one day
11 21 hr. min.

9. Birthplace *Baltimore, Maryland*
(town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *John Charles Lisciairo*

13. Birthplace *New York (Jamestown)*

14. Maiden Name *Mary Paternini*

15. Birthplace *New York (Jamestown)*

16 (a) Informant *father*

(b) Address *3615 Woodbine Avenue*

17 (a) *Burial* (b) Date thereof *10/18/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *New Cathedral*
Location *Balto., Md.*

18 (a) Funeral director *Wm. J. Zuker & Son*

(b) Address *Balto., Md.*

19 (a) (Date of registration) *OCT 18 1943* (b) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 15, 1943 at 11:05 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *October 9, 1943* to *October 15, 1943* and that I last saw him alive on *October 15, 1943*.

Immediate cause of death

Cardio Respiratory Failure

Due to *Septicemia*

Due to

Due to

Other Conditions *Analytic Stasis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *John R. Davis, Jr.*

Mary Hospital Date signed *10/15/43*

Duration

4 days

over

12 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09176

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *St. Joseph's Hospital*

(c) Hospital or institution: *Baltimore Md.*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *44 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Harford*

(c) City or town *Rural, Forest Hill*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Catherine Poteet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced *married*

6 (b) Name of husband or wife *James H. Poteet*

6 (c) If alive, give age *72 years*

7. Birth date of deceased (mo., day, yr.) *Feb 27 1918*

8. AGE: Years *45* Months *7* Days *15* If less than one day hr. min.

9. Birthplace *Glenview, Baltimore, Md*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Robert Roach*

13. Birthplace *Ireland*

14. Maiden Name *Jane?*

15. Birthplace *Ireland*

16 (a) Informant *J. H. Poteet*

(b) Address *Forest Hill Md*

17 (a) *Burial* (b) Date thereof *Oct 20 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. John's*
Location *Long Green Rd, Baltimore Md*

18 (a) Funeral director *St. John's*

(b) Address *Cambridge Md.*

OCT 18 1943

VB 146

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 18 1943* at *12:10 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 4 1943* to *Oct 18 1943*, and that I last saw him alive on *Oct 18 1943*.

Immediate cause of death *Myocardial Infarction*
Coronary Artery Disease

Due to *Diabetic Mellitus*

Due to

Other Conditions *Cellulitis & Gonorrhea*
Unoperated Mid Leg Stump

Date of operation *Oct 18 1943*

Major findings of operation *Cellulitis*
Sanguine Pt For
of autopsy *Refused*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury *William H. Hight*

23. Signature *William H. Hight*
Address *St. Joseph's Hospital* Date signed *10/18/43*

G 09177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09177

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. *none*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

12 hr. min.9. Birthplace *Balto. Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Joan J. Buczinski*13. Birthplace *Baltimore, Md.*14. Maiden Name *Marie Matijovic*15. Birthplace *Baltimore, Md.*16 (a) Informant *L. Marie Buczinski*(b) Address *2202 E. Monument*17 (a) *Burial* (b) Date thereof *10/18/43*(c) Cemetery or crematory *Holy Redeemer*Location *Belair Road*18 (a) Funeral director *Chas. B. Schumann*(b) Address *2601 E. Madison*19 (a) (b) *Oct 18 1943*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore, Md.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2202 E. Monument*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 17* 19 *43*, at *2:40 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 6* 19 *43*, to *Oct. 17* 19 *43*, and that I last saw her alive on *Oct. 17* 19 *43*.

Immediate cause of death

prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Christian F. Richter*Address *St. Joseph's Hosp.* Date signed *10/17/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

442872
G 09178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09178

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **md** (b) County **Baltimore**
(c) City or town **Annapolis Point**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **607 E. St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James J Mahon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Florence

6 (c) If alive, give age **39** years

7. Birth date of deceased (mo., day, yr.)

7-19-02

8. AGE:

Years

Months

Days

If less than one day

41

2

26

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

Shipyard Worker

11. Industry or business

FATHER
MOTHER

12. Name

Patrick Mahon

13. Birthplace

Pa.

14. Maiden Name

Rose Thompson

15. Birthplace

md

16 (a) Informant

(b) Address

**Records
JOHNS HOPKINS HOSPITAL**

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Oct 1943

(c) Cemetery or place of interment

Location

**Oak Lawn
Eastern Ave Bk.**

18 (a) Funeral director

(b) Address

**John E. Moran
3000 E. Baltimore St.**

19 (a)

(b)

OCT 18 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct-15-**

1943, at **11** **A**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct-14** 1943, to **Oct-15** 1943, and that I last saw him alive on **Oct-15** 1943.

Immediate cause of death

Septicemia - organism unknown

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Russell A. Nelson

Address

Johns Hopkins Hosp

signed **Oct 15 1943**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09179
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Maryland

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1915 Homewood Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John - Kelly

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 11 - 1879

8. AGE:

Years

Months

Days

If less than one day

64

8

5

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Printer

11. Industry or business

Self

FATHER
MOTHER

12. Name

Timothy Kelly

13. Birthplace

Ireland

14. Maiden Name

Mary E. Mooney

15. Birthplace

Ireland

16 (a) Informant

Katharine Kelly

(b) Address

1915 Homewood Ave

17 (a)

Burial

(b) Date thereof

10/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Edmondson Ave

18 (a) Funeral director

John E. Moran

(b) Address

2000 Baltimore

19 (a)

OCT 18 1943

(b)

Huntington Williams

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 16 1943 1 P. M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10-14 1943 to 10-16 1943

and that I last saw him alive on 10-16 1943

Immediate cause of death

Hypertensive
cardiovascular disease

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Due to

Duration

2

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

St. Joseph's Hospital

Date signed 10-16-43

G 09180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09180

Registered No.

PLEASE WRITE FAIRLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Jinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1707 N Pulaski St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Louis Silverfarb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1871

8. AGE:

Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Drygood Store

FATHER

12. Name: Morris Silverfarb

13. Birthplace

Russia

MOTHER

14. Maiden Name

Mary ?

15. Birthplace

Russia

16 (a) Informant: Maurice Silverfarb

(b) Address: 4420 Reisterstown Road

17 (a) Burial

(b) Date thereof: Oct, 18, 1948

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Herring Run Cem

Location

Bowleys Lane Ohel Yokov Cong

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124 1126 W North Ave

19 (a)

1818 N. Lexington Millersville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/17

1948 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1948 to 10/17 1948, and that I last saw him alive on 10/17 1948.

Immediate cause of death

Chemia

Due to

Central - nervous acc.

Due to

Hypertension & I.S. H.I.

Other Conditions

Pastor's Certificate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Leonard E. Meisels

Address

Jinai Hosp

Date signed

10/17/48

LEONARD E. MEISELS, M.D.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09181

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1943 to 10/16 1943, and that I last saw him alive on 10/13 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians; please write the cause of death clearly and legibly.

G 09182
438417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09182
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 4

3 (a) FULL NAME

LOUISE RITSHER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEMALE WHITE

5. Color or race

6 (a) Single, married, widowed, or divorced.

Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-69

8. AGE: Year Months Days If less than one day

74 2 11 hr. min.

9. Birthplace

N.Y.

10. Usual Occupation

11. Industry or business

12. Name ISAACS HOLMES

13. Birthplace

N.Y.

14. Maiden Name SARAH BUZZELL

15. Birthplace

VERMONT

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) ~~Cremation~~ (b) Date thereof

Oct 18/43

(Burial, cremation, or removal)

(c) ~~Crematory~~

Location

London Park

18 (a) Funeral director

(b) Address

1910 Eastman Place

19 (c)

(Date rec'd by Registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Catonsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6608 Ramoth Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1943, 945 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1943, to Oct 16 1943, and that I last saw her alive on Oct 16 1943.

Immediate cause of death Uremia

Duration

Due to Chronic nephritis
Hypertensive cardiovascular disease

Due to

Other Conditions Gen. arteriosclerosis
Anemia, Hydrothorax

(Include pregnancy within 3 months of death)

Date of operation Exploratory laparotomy

Major findings of operation:

No organic lesions found
of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E.S. Cross Jr

Address J.H.H.

Date signed 10-16-43

OCT 18 1943

G 09183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09183

Registered No.

93d

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1732 N. Bond Street
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1732 N. Bond Street
 (If rural give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country:

3 (a) FULL NAME

Emma Schurr

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Charles Schurr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16th, 1868

8. AGE: Years Months Days If less than one day
 75 7 29 min.

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Ferdinand Dittell

13. Birthplace France

14. Maiden Name Margaret Walters

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Rose Price (Sister)

(b) Address 2225 Purnell Drive

17 (a) Burial (b) Date thereof Oct. 16, 1943
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.
 Location E. North Ave. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) (b)
 (Date signed by registrar) H. J. Wilkins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15th 1943 at M

21. I certify that death occurred on the date above stated; that I attend-
 ed deceased from Aug. 26 1943 to Oct. 15 1943.
 and that I last saw her alive on Oct. 14 1943.

Immediate cause of death

Chronic Myocarditis
 Generalized Arterio-
 sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
 place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Samuel Spolfe
 Address 1531 E. North Ave. Date signed 10-16-43

Duration

2 yrs.

2 yrs.

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

G 09184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09184

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2325 Tucker Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1945, at 7:05 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from June 1, 1943, to Oct 15, 1945.

and that I last saw him alive on Oct 12, 1945.

Immediate cause of death

Hypostatic pneumonia

Myocarditis

Due to advanced atherosclerosis

Due to

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

220 Garrison Blvd

Date signed

M. D.

Oct 18/45

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09185

09185

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1135 N. Milton Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Leroy R. Brandt

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 213-05-9828

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary W. Brandt

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr) Nov. 4 - 1903

8. AGE: Years Months Days If less than one day

39

11

12

hr.

min.

9. Birthplace

Balt. Md

(Town, county, and state)

10. Usual Occupation

Mechanic

11. Industry or business

Balt. Transit Co.

FATHER
MOTHER

12. Name Wm Brandt

13. Birthplace Balt. Md

14. Maiden Name Anne R. Gajdos

15. Birthplace Md.

16 (a) Informant Mary W. Brandt

(b) Address 1135 N. Milton Ave

17 (a) Burial (b) Date thereof 10/18/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore Cemetery

Location

6600 N. 1st Ave.

18 (a) Funeral director Elmer J. Oakland

(b) Address 924 E. B. Ave. N.

OCT 18 1943

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-1943 at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions Multiple locomotor embolism & blood borne. Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-16- at 12.35 A M

(b) Where did injury occur? Md. Ave. 25th St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

Means of injury Struck car ran over body.

23. Signature Harold J. Hadden

M.D.

Date signed 10-16-43

Medical Examiner.

G 09186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09186

131a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address La Fayette and John Streets

(c) Hospital or institution:

HOSPITAL FOR WOMEN OF Maryland(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 22 Bristol Ave
(If rural give location)(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

MRS MARGARET VIRGINIA LEWIS

3 (b) If veteran, name was

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife MR JULIAN C. LEWIS6 (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) AUGUST 15, 18868. AGE: Years Months Days If less than one day
57 2 1 hr. min.9. Birthplace SUNNYBANK VIRGINIA
(Town, county, and state)10. Usual Occupation HOUSEWIFE

11. Industry or business

12. Name RICHARD ABBOTT13. Birthplace STAFFORD COUNTY VIRGINIA14. Maiden Name SARAH COOKMAN15. Birthplace RICHMOND COUNTY VIRGINIA16 (a) Informant Husband Julian C. Lewis(b) Address 22 Bristol Ave17 (a) Burial (b) Date thereof 10/19/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Glen HavenLocation Ritchie Highway18 (a) Funeral director Howard N. Blight, Jr.(b) Address 4914 Belair Road19 OCT 18 1943 Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 43 at 11:06 AM21. I certify that death occurred on the date above stated; that I attended deceased from October 14 19 43, to October 16 19 43 and that I last saw him alive on October 16 19 43Immediate cause of death RESPIRATORY COLLAPSE, HYPERPYREXIADue to Cerebral HemorrhageDue to HYPERTENSIVE, ARTERIOSCLEROTIC Cardio-Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Marland Edward Day M. D.
Address Women's Hospital Date signed Oct 16, 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09187

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date of registration)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 3 p. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1943, to Oct 16 1943, and that I last saw him alive on Oct 15 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. H. Catterman

Address 2324 Reisterstown Rd

Date signed 9/17/43

VS 124

OCT 18 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is especially important. Physicians: please write the cause of death clearly and legibly.

09188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1246G 09188
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1 S. Payson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1 S. Payson St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Rosetta C. Ball

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-01-5707

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife John W. Ball

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1, 1878

8. AGE: Years Months Days If less than one day
65 1 14 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Hochschild, Kohn & Co.

12. Name George W. Pilson

13. Birthplace Baltimore, Md.

14. Maiden Name Carrie L.

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. J. Fred Ball

(b) Address 5307 Dorchester Road

17 (a) Burial (b) Date thereof Oct. 18, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Baltimore, Md.

18 (a) Funeral director E. W. Hamon

(b) Address 1003 W. Baltimore St.

19 (a) OCT 18 1943 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1943 6.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1943 to 10/15 1943 and that I last saw her alive on 10/15 1943

Immediate cause of death

CARDIAC DECOMPRESSION
ARTRICULAR FIBRILLATION
DUE TO MYO CARDITIS
CIRRHOSIS OF LIVER

Duration

5 days
1 1/2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature E. W. Hamon M. D.

Address 1945 W. Baltimore St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09189

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal)

(b) Date thereof (month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 18 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

a. State

b. County

c. City or town

(If outside city or town limits, write RURAL and give town)

d. Street No.

(e) Citizen of foreign country?

If yes, name country

Yes or No

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11/43 to 10/12/43 and that I last saw him alive on 10/12/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

G 09100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09190
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-0

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Grace, Mark (Mark)

3 (b) If veteran, name war

3 (c) Social Security Account

No 215-10-9642

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1875

8. AGE: Years Months Days If less than one day

67 11 21 hr min

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Credit Dept

11. Industry or business

Hochschild & Kohn

FATHER

12. Name

William Mark

13. Birthplace

Unknown

MOTHER

14. Maiden Name

Lola H. Mark

15. Birthplace

Unknown

16 (a) Informant

Bessie T. Stein

(b) Address 3702 Forest Park Ave

17 (a)

Burial

Date thereof Oct 19 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

David Ridge

Location

Baltimore Md

18 (a) Funeral director

Harry H. Ammer

(b) Address 4204

Baltimore Md

19 (a)

OCT 18 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 3702 Forest Park Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1943, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured base of skull

Due to

Other Conditions

Multiple lacerations, contusions and blood burns.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-15- at 2:30 P M

(b) Where did injury occur? Liberty Heights - Calloway Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian, struck by street car

23. Signature Howard J. Goldstein

M.D.

Date signed 10-16-43

Medical Examiner.

G 09191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09191

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2913 Oakhill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days

02 yrs

3. (a) FULL NAME

Charles E. McLean

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-12-4616

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Susanna E. McLean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 16 / 1863

8. AGE:

Years

Months

Days

If less than one day

80

1 yr

hr

min.

9. Birthplace

Baltimore Md

10. Usual Occupation

Retired at B. & O. Railway

11. Industry or business

Baltimore City

FATHER

12. Name

Joseph McLean

13. Birthplace

Baltimore Md

MOTHER

14. Maiden Name

Julia Ann Freedbird

15. Birthplace

Baltimore Md

16 (a) Informant

Susanna E. McLean

(b) Address

2913 Oakhill Ave

17 (a)

Burial

(b) Date thereof

Oct 20 / 1943

(c) Cemetery or crematory

Woodlawn

(d) Location

Woodlawn Md

18 (a) Funeral director

Harry J. Limerick

(b) Address

2913 Oakhill Ave

19 (a)

(b) Date rec'd by registrar

Registrar

OCT. 18 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2913 Oakhill Ave

(If rural give location)

(e) Citizen of foreign country?

Yes or No

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 / 18

1943, at 12:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8:25 1943, to 10:17 1943, and that I last saw him alive on 10:17 1943.

Immediate cause of death

Coronary thrombosis

Duration

24 hrs

Due to

Due to

Other Conditions

Arterio sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles E. McLean

Address

2902 Woodlawn

Date signed

10/18/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09192

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

XV
46E

G 09192
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial, cremation, or removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date rec'd by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct, 17 1943, at 7⁴⁰ A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Oct 17 1943 and that I last saw him alive on Oct 16 1943.

Immediate cause of death PERFORATION of SESUM.

Due to CARCINOMA.

Due to

Other Conditions PERITONITIS

(Include pregnancy within 3 months of death)

Date of operation SEPT 16, 43

Major findings of operation:

CARCINOMA

of autopsy SAME

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature Edwin H. Skewert

Address W. Nosp

Date signed 10/17/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09193

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09193

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12 S. Washington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 12 S. Washington
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANTHONY R. CAVENDER

3 (b) If veteran, name war

3 (c) Social Security Account

No. 714-05-6649

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Alice E. Croghan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1898

8. AGE: Years Months Days If less than one day
45 1 12 hr. min.9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Rival Express Co.

12. Name Anthony Cavender

13. Birthplace Md.

14. Maiden Name Margaret Fidler

15. Birthplace Md.

16 (a) Informant Mrs. Alice Cavender

(b) Address 12 S. Washington St.

17 (a) Burial (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director E. J. Fanning, Jr.

(b) Address 1938 E. J. Fanning Ave.

19 OCT 18 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943, at 9:45 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry
thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature R. A. Wallenmeyer M.D.
Medical Examiner.

Date signed 10-18-43

Physicians: please write the causes of death clearly and legibly.

G 09194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 G 09194

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 620 N. Carrollton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Gladys Hall Frederick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

6

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Frederick

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov 17 1901

8. AGE: Years

42

Months

7

Days

27

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

10. Usual Occupation

Housewife

11. Industry or business

12. Name

George Hall

13. Birthplace

Baltimore, Md.

14. Maiden Name

Rose Brooks

15. Birthplace

Baltimore, Md.

16 (a) Informant

Helen Smith

(b) Address

620 N. Carrollton Ave

17 (a) Burial

(b) Date thereof Oct. 18 1943

(c) Cemetery or crematory

W. H. C. Cemetery

Location

W. H. C. Cemetery

18 (a) Funeral director

W. H. C. Cemetery

(b) Address

721 N. Carrollton St

19 (a) Date rec'd by

Oct 18 1943

(b) Signature

Huntington

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(d) Street No 620 N. Carrollton Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-14-1943 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/43 to 10/14/43

and that I last saw him alive on 10/14/43

Immediate cause of death

Myocardial infarction

Due to

Myocardial infarction

Due to

Myocardial infarction

Other Conditions

Myocardial infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

2616 Gough St

2616 Gough St

2616 Gough St

2616 Gough St

2616 Gough St

2616 Gough St

G 09195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09195

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5458 Frederick Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5458 Frederick Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Ellen M. Wright

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

home

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed6 (b) Name of husband or wife Martin J. Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1866

8. AGE: Years Months Days If less than one day

7760

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

House work

11. Industry or business

at homeFATHER
MOTHER12. Name Michael J. M. - Swine13. Birthplace Ireland.14. Maiden Name K. Jane Fitzgerald15. Birthplace Ireland16 (a) Informant Mrs. Phillip A. Gandy(b) Address 5458 Frederick Ave17 (a) Burial (b) Date thereof 10-19-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium New Cathedral CenLocation Balti. Md.18 (a) Funeral director John C. Brown & Son(b) Address 801 Hollis St.19 (a) OCT 18 1943

(Date of registration)

Huntington Hill, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1943 at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10-15-43 M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh M. Kelly M.D.

Medical Examiner.

Date signed 10-15-43Howard J. Walden, M.D.

09196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *218 S. Maderia*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Thomas A. Suchnicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 28-1942*

8. AGE: Years Months Days If less than one day

1 1 20 19 hr. min.9. Birthplace *Balto Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Adam Suchnicki*13. Birthplace *Balto.*14. Maiden Name *Jenny Aleksalza*15. Birthplace *Balto.*16 (a) Informant *Adam Suchnicki*(b) Address *218 S. Maderia*17 (a) *Burial* (b) Date thereof *10-19-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Holy Rosary*
Location *German Hill Rd.*18 (a) Funeral director *W. S. Fialkowski*(b) Address *1802 Eastern Ave*19 (a) *OCT 18 1943* (b) *Huntington Williams, M.D.*
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Balto.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *218 S. Maderia*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 17 1943 at 1:30 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 15 1943* to *Oct. 17 1943* and that I last saw him alive on *Oct. 16 1943*

Immediate cause of death

Bronchopneumonia Duration *4 days*

Due to

Due to

Other Conditions

Rickets.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *John V. Jerszinski*Address *1802 Eastern Ave* Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

466 G 09197
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1518 Piggs Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

3 (a) FULL NAME

Narah Muelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Joseph Muelman

(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Benj. Narin

13. Birthplace

Russia

14. Maiden Name

Rebecca

15. Birthplace

Russia

16 (a) Informant

Joseph Muelman

(b) Address

Stevensville Md.

17 (a)

Burial

(b) Date thereof 10-18-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

United Hebrew Cem.

Location

Washington Blvd.

18 (a) Funeral director

Joe Weiss

(b) Address

1739 18th St

19 (a)

18 OCT 18 1943

Huntington Williams, Md.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Queen Anne

(c) City or town

Stevensville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-17-43

1943

9:40 P.

M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Oct 17 1943 and that I last saw him alive on Oct 17 1943.

Immediate cause of death

Carcinoma of ascending colon

Due to

Due to

Other Conditions

Cardiac asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Benj. Haden

Address 2306 Euter

Date signed 12-18-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83 G 09198
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Lincol Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2333 Eutan Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Bessie Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

James Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1884

8. AGE:

59

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Michael Schwartz

13. Birthplace

Russia

MOTHER

14. Maiden Name

Recheel -

15. Birthplace

Russia

16 (a) Informant

Hal Miller

(b) Address

7010 K. Hwy. As

17 (a)

Burial

(b) Date thereof

10-18-45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Southam Ave

Location

18 (a) Funeral director

Joe Lewis Inc

(b) Address

1734 E. Baers

19

OCT 18 1945

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 17 1945 at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Oct 17 1945, and that I last saw her alive on Oct 17 1945.

Immediate cause of death

Subarachnoid Hemorrhage

Due to

Hypertension

Due to

Other Conditions

Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Cerebral
Punctures: Blood Fluid, Xanthoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert M. Jacobs

Address

Lincol Hosp.

Date signed 10/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09200

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **1 day**
(e) Length of stay in Baltimore (yrs., mos., or days) **1 day**

2. USUAL RESIDENCE OF DECEASED:

(a) State **N.Y.** (b) County
(c) City or town **New York City**
(If rural, give city or town, and give location) **670 Henry St., Apt. 6A**
(d) Street No. **41 Convent Ave., Apt. 6A**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME **HENRY CANTY**

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **Col.** 6 (a) Single, married, widowed, or divorced **Single**

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **March 5, 1893**

8. AGE: Years **50** Months **7** Days **7** If less than one day
hr. min.

9. Birthplace **Beauford, South Carolina**
(Town, county, and state)

10. Usual Occupation **Merchant Seaman- 2nd Cook**

11. Industry or business

12. Name **Gusy Canty**
13. Birthplace **Beauford, S. C.**

14. Maiden Name **Mary I**
15. Birthplace **Beauford, S. C.**

16 (a) Informant **Records, U.S. Marine Hospital**
(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10-18-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **calutus**
Location **md**

18 (a) Funeral director **George H. Nelson**
(b) Address **1303 Prerstan St**

19 (a) **10-18-1943** (b) **Huntington Hollinsworth**
(Date of death) (Signature of Registrar)

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **October 12, 1943, 11:45 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 11, 1943** to **Oct. 12, 1943**, and that I last saw him alive on **Oct. 12, 1943**.

Immediate cause of death **Acute hemorrhage involving the pons base of the brain & floor of the fourth ventricles.**
Due to

Duration
1 day

Due to

Other Conditions **Bilateral pulmonary congestion & edema with early pneumonia**
(Mention pregnancy within 2 months of death)

Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation

Major findings of operations

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury **10.5.75**
23. Signature

Address **Baltimore, Md.** Date signed **10/13/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09201
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Harford*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *43 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1913 Mount St*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Gamer Robert Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

Bl

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife *Mrs. Bernie Keys*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1900

8. AGE: Years

43

Months

Days

If less than one day

hr.

min.

9. Birthplace *D. Mang's County Md*

(Town, county, and state)

10. Usual Occupation *Artist Worker*

11. Industry or business

12. Name *Robert Keys*

13. Birthplace *Maryland*

14. Maiden Name *Mary Curtis*

15. Birthplace *Maryland*

16 (a) Informant *Mrs. Bernie Keys*

(b) Address *1913 Mount St*

17 (a) *Burial* (b) Date thereof *10/18/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St Peter*

Location

18 (a) Funeral director *Geo. H. Kelso*

(b) Address *1203 P. Eastman*

OCT 18 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 16* 1943, at *9 A M*

21. I certify that death occurred on the date above stated, that I attended deceased from *Oct 8* 1943 to *Oct 16* 1943, and that I last saw him alive on *Oct 6* 1943.

Immediate cause of death *Cardio. Resp. Failure*

Duration

Due to 1- *Pneumonia*

2- *Paralytic & slow*

Due to *Asplenic degeneration & Prostate cancer*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: *Asplenic degeneration & Prostate cancer*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature *Thomas F. Oederholt*

Address *Mercy Hosp.*

Date signed *10/16/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09202

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 641 Timbudge Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 641 Timbudge Road
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No 212-05-0478

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of husband or wife Lula N Long6 (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) May 5-1882

8. AGE:

Years

Months

Days

If less than one day

61512

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Telephone Inspector

11. Industry or business

FATHER
MOTHER

12. Name

William Long

13. Birthplace

Md

14. Maiden Name

Arabelle Rulley

15. Birthplace

Md

16 (a) Informant

Mrs Joe N Long

(b) Address

641 Timbudge Road17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 27/43

(c) Cemetery or crematory

Hampstead

Location

Hampstead Md

18 (a) Funeral director

Edw E Gipton

(b) Address

Hampstead Md19 18 1943Hamington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1943 6:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from June 30, 1939 to Oct 17, 1943, and that I last saw him alive on Oct. 17, 1943.

Immediate cause of death

Mitral stenosisAortic regurgitation

Due to

Due to

Other Conditions Passive congestion
of Liver.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Dr. Mark H. Singard

M. D.

Address

1613North Ave.Date signed 10-18-43

09203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09203
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1736 S. Hanover St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *42*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Margaret Higginson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

*White*6 (a) Single, married, widowed, or
divorced.*Married*6 (b) Name of husband or wife *Michael Higginson*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 27-1865*

8. AGE:

Years

Months

Days

If less than one day

*78**-6**-19*

hr.

min.

9. Birthplace

Balto. Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

William Hamburger

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany

16 (a) Informant

Dr. Edward Higginson

(b) Address

1708 S. Hanover St

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

Balto. Md. Ritchie Highway

18 (a) Funeral director

Walter Schelling

(b) Address

3914 S. Hanover St

(c) Address

Huntington Williams, Md.

OCT 18 1943

(Date of death)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1736 S. Hanover St*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 16* 19*43* at *11:10* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 14* 19*43* to *Oct 16* 19*43*, and that I last saw her alive on *Oct 16* 19*43*.

Immediate cause of death

Exhaustion

Due to

Duration

2 day

Due to

*Cerebral Hemorrhage**1 mo.*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

R. L. Campbell

Address

1736 S. Hanover St

Date signed

10/16/43

09204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09204
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1606 N. Regester St
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

DAVID HENRY

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 21-1939

8. AGE: Years Months Days If less than one day

4 4 21/23 hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name JOSEPH W. HENRY13. Birthplace CLEAR SPRINGS MD14. Maiden Name MARY D YOUNG15. Birthplace BRANSONVILLE MD16 (a) Informant JOSEPH W. HENRY(b) Address 1606 N. REGESTER ST17 (a) BURIAL (b) Date thereof 10/18/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory MIRELAND MEM.Location TAYLOR AVE18 (a) Funeral director Blanca P. Hoffmann(b) Address 1639 N. Broadway19 OCT 18 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18, 1943 at 10:55 PM

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☒, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Burns, 2nd + 3rd degree
entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 10-18-43 at 4:00 PM(b) Where did injury occur? back yard at home(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? no(d) Means of injury clothes caught on fire23. Signature H. W. Wallenmeyer M.D.Date signed 10-18-43

09205

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09205
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Bok Secours Hospital*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town *Baltimore*
(If outside city or town limits, write R.U.R. and give town)(d) Street No. *1436 N. 37th Street*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.4 Sex *Male*5 Color, complex *White*6 (a) Single, married, widowed, or divorced. *Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Mar. 20-1942*8. AGE: Years Months Days If less than one day
10 25 hr. min.9. Birthplace *Baltimore, Maryland*
(City, town, county, and state)10. Usual Occupation *At home*

11. Industry or business

12. Name *Donald Walter Sheeler*13. Birthplace *Maryland*14. Maiden Name *Belen Keturah Ruffington*15. Birthplace *Maryland*16 (a) Informant *Donald J. Sheeler*(b) Address *1436 N. 37th Street*17 (a) *Burial* (b) Date thereof *Oct. 19-1943*
(Burial, cremation, or removal) (Month) (day) (year)(c) Cemetery or crematory *N. Marys (Fam. Bur.)*Location *Baltimore, Maryland*18 (a) Funeral director *Burgess Funeral Home*(b) Address *3631 Fells Road*(b) *Huntington Williams, M.D.*

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/15* 19 *43* at *11:30 PM*21. I certify that death occurred on the date above stated, that I attended deceased from *10/15* 19 *43* to *10/15* 19 *43* and that I last saw him alive on *10/15* 19 *43*

Immediate cause of death

*Broncho-pneumonia*Duration
24 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *10/15/43*Major findings of operations *neg. aut.*

Laboratory.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Lymered Rayer* M. D.Address *Bok Secours Hosp* Date signed *10/15/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09206

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 847 Hollington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 39 years

3 (a) FULL NAME

Frederick Harry Stallman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara Elizabeth Stallman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1868

8. AGE: Years 75 Months - Days - If less than one day hr. min.

9. Birthplace York, Pennsylvania

10. Usual Occupation Fireman, P.R.R.

11. Industry or business Retired

12. Name John Stallman

13. Birthplace Pennsylvania

14. Maiden Name Katherine Lee Hoff

15. Birthplace Pennsylvania

16 (a) Informant Mrs. Clara E. Stallman

(b) Address 847 Hollington St.

17 (a) Burial (b) Date thereof Oct. 20 - 1943

(c) Cemetery or crematory Roudon Park

Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3621 Falls Road

19 (a) OCT 18 1943 (b) Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Hollington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 - 1943 at 11 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1940 to Oct 16th 1943 and that I last saw him alive on Oct 16th 1943

Immediate cause of death Acute Cordarodilation

Marked general arteriosclerosis

Due to Coronary atherosclerosis

Due to Partial prostatic

Other Conditions General Debility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature B. J. Linder
Address 3614 Fairview Rd. Date signed 10/16/43

Duration 30 min

54

1841

1941

1941

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13-1000-09207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09207

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4808 Edmondson Ave**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **50 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **4808 Edmondson Ave**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Henrietta Belle Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Widow

6 (b) Name of husband or wife **Late Dr. Addison O. Fox**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) **Feb. 29, 1864.**

8. AGE:

Years

Months

Days

If less than one day

79

7

16

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

John H. Treakle

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Julia Ann Dunton

15. Birthplace

Virginia

16 (a) Informant

Mr. Sharon H. Fox

(b) Address

4808 Edmondson Ave.

17 (a)

Burial

(b) Date thereof **Oct. 18, 1943**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

4801 Fredrick Rd.

18 (a) Funeral director

Harry H. Witske

(b) Address

4101 Edmondson Ave

19

OCT 18 1943

(Date rec'd by registrar)

William H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 15 1943** **11:15 AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **10/7 1943** to **10/15 1943** and that I last saw him alive on **Oct 15 1943**.

Immediate cause of death

Coronary Occlusion

Due to **Arterio sclerosis**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Carol H. King**

Address **1324 W. Lombard St** Date signed **10/16/43**

Duration

10/5/43

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09208 21 name

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09208
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Green + Redwood*
(c) Hospital or institution: *University*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *19-13*
(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F.* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced. *married*

6 (b) Name of husband or wife *Sammy B.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 13, 1883*

8. AGE: Years *60* Months *5* Days *1* If less than one day hr. min.

9. Birthplace *Baltimore Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Arthur Tuttle*

13. Birthplace *Md*

14. Maiden Name *Louise Clifford*

15. Birthplace *Md.*

16 (a) Informant *Mr. Sammy B. Lintand*

(b) Address *203 S. Gilman St.*

17 (a) *Burial* (b) Date thereof *19/19/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Louisa Park*
Location *Balto. Md.*

18 (a) Funeral director *Harry A. Fitzke*

(b) Address *4101 Edmondson Ave.*

19 (a) *OCT 18 1943* (b) Registrar *Thurston Williams, M.D.*

VB 154

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *203 S. Gilman St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 16 1943 10:30 AM*

21. I certify that death occurred on the date above stated, that I attended deceased from *Oct 10 1943* to *Oct 16 1943*, and that I last saw him alive on *Oct 16 1943*

Immediate cause of death

Respiratory failure
Due to *Cerebrovascular hemorrhage*
Due to

Other Conditions *Pneumonia*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature *David K. Worgan*
Address *University Hosp.* Date signed *10/18/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT			G 09209		
CERTIFICATE OF DEATH			Registered No. 1600		
1. PLACE OF DEATH:			2. USUAL RESIDENCE OF DECEASED:		
(a) Baltimore City, Maryland			(a) State <u>MD</u> (b) County		
(b) Street address <u>2025 W. Fayette St. Balto.</u>			(c) City or town <u>Baltimore - 16,</u>		
(c) Hospital or institution: <u>Bon Secours Hospital</u>			(d) Street No. <u>3233 Powhatan Ave.</u>		
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>11 Days</u>			(e) Citizen of foreign country? (Yes or No)		
(e) Length of stay in Baltimore (yrs., mos., or days) <u>11 Days</u>			If yes, name country		
3 (a) FULL NAME <u>Vincent Hughes Stafford Jr.</u>			MEDICAL CERTIFICATION		
3 (b) If veteran, name war			20. DATE OF DEATH <u>10-18-1943 7:30A.M.</u>		
3 (c) Social Security Account No.			21. I certify that death occurred on the date above stated; that I attended deceased from <u>10-7-43 1943</u> to <u>10-18-1943</u> , and that I last saw him alive on <u>10-18-43</u> 19.		
4. Sex <u>M.</u>	5. Color or race <u>W.</u>	6 (a) Single, married, widowed, or divorced. <u>Single</u>	Immediate cause of death		
6 (b) Name of husband or wife			Due to		
6 (c) If alive, give age years			Due to		
7. Birth date of deceased (mo., day, yr.) <u>10-7-43</u>			Other Conditions		
8. AGE: Years	Months	Days	(Include pregnancy within 3 months of death)		
		<u>11 Days</u> hr. min.	Date of operation		
9. Birthplace <u>Bon Secours Hospital, Balto.</u>			Major findings of operations		
(Town, county, and state)			of autopsy		
10. Usual Occupation <u>None</u>			22. If death was due to external causes, fill in the following:		
11. Industry or business <u>None</u>			(a) Accident, suicide, or homicide		
12. Name <u>Vincent Hughes Stafford</u>			(b) Date of occurrence at <u>M</u>		
13. Birthplace <u>Baltimore Md.</u>			(c) Where did injury occur? (City or town) (County) (State)		
14. Maiden Name <u>Ruth Lee Sunderland</u>			(d) Did injury occur about home, on farm, industrial place, in public place? While at work?		
15. Birthplace <u>Brooklyn New York</u>			(Specify type of place)		
16 (a) Informant <u>Mr. Vincent H. Stafford</u>			(e) Means of injury		
(b) Address <u>3233 Powhatan Ave.</u>			23. Signature <u>Charles P. Jerny</u>		
17 (a) <u>Burial</u> (b) Date thereof <u>10/18/43</u>			Address <u>Bon Secours Hosp</u> Date signed <u>10/18/43</u>		
(Burial, cremation, or removal) (month) (day) (year)			M. D.		
(c) Cemetery or crematory <u>New Cathedral</u>					
Location <u>Baltimore Md.</u>					
18 (a) Funeral director <u>Harry H. White</u>					
(b) Address <u>4101 Edmondson Ave</u>					
OCT 18 1943 (Date filed by Registrar)					
VS 3 <u>Huntington Williams, M.D.</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107 G 09210
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7- S. Carlton st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Kathleen Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-23-43

8. AGE:

Years

Months

Days

If less than one day

23

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Davis

13. Birthplace

Va

14. Maiden Name

Essie Walker

15. Birthplace

N.C.

16 (a) Informant

Essie Walker

(b) Address

7- S. Carlton st

17 (a)

Burial

(b) Date thereof

10-18-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

St. Auburn Em

Location

Baltimore Md

18 (a) Funeral director

William A. Jackson

(b) Address

916 Pennsylvania

19 (a)

Date rec'd by registrar

Huntington Williams

V8 156

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

7- S. Carlton st

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 17

1943 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943 to Oct 17 1943 and that I last saw her alive on Oct 17 1943.

Immediate cause of death

Dissected pneumonia (Pneumonia)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 03211
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) P.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)

(d) Street No. 406 Pearl St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Henry Nathaniel Tripp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-1919

8. AGE: Years Months Days If less than one day
24 1 13 hr. min.

9. Birthplace Greensboro N.C.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

12. Name Amos Tripp

13. Birthplace N.C.

14. Maiden Name Mabel Harris

15. Birthplace N.C.

16 (a) Informant Dora Tripp

(b) Address 406 Pearl St

17 (a) Shipped (b) Date thereof 10-19-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greensboro Cem
Location Greensboro N.C.

18 (a) Funeral Director William A. Jackson

(b) Address 916 Pearl St
Huntington Williams, Md.

19 (a) (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1943 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed October 19 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 51st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **4 mos. 19 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md.** (b) County _____
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **1003 S. Belnord Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3 (a) FULL NAME **FRANK KOWALSKI**

3 (b) If veteran, name war **World's War**
3 (c) Social Security Account No. **216-058662**

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Mary Chester**
6 (c) If alive, give age **49** years

7. Birth date of deceased (mo., day, yr.) **Oct. 4, 1895**
8. AGE: Years **48** Months **0** Days **11** If less than one day
_____ hr. _____ min.

9. Birthplace **Baltimore, Md.**
(Town, county, and state)

10. Usual Occupation **Oyster Shippers 3/5/43**
11. Industry or business **(Oysters) McGee Co. 3/5/43**

FATHER
12. Name **Joe Kowalski**
13. Birthplace **Poland**
MOTHER
14. Maiden Name **Mary ?**
15. Birthplace **Poland**

16 (a) Informant **Records, U.S. Marine Hospital**
(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10/14/43**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory **Cemetery**
Location **Baltimore National**

18 (a) Funeral director **Stephen J. Halbrook**
(b) Address **1000 P. Remond**

19 (a) **OCT 18 1943** Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 18, 1943** at **12:00 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **May 27, 1943** to **Oct. 15, 1943**, and that I last saw him alive on **Oct. 15, 1943**.

Immediate cause of death **Carcinoma of larynx with cervical metastases**

Due to _____
Due to _____
Other Conditions _____

(Include pregnancy within 3 months of death)
Date of operation **5/31/43** **Tracheostomy**
Major findings of operation **Carcinoma of larynx and base of tongue with cervical node metastases**
of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide **No**
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury **10/18/43**
23. Signature **J. S. Th...**
Address **Baltimore, Md.** Date signed **10/18/43**

G 09213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09213

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William Noonan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1894

8. AGE: Years Months Days If less than one day

49

1

14

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Gardening

11. Industry or business

FATHER
MOTHER

12. Name

Wm. J. Noonan

13. Birthplace

Ireland

14. Maiden Name

Nora Burns

15. Birthplace

England

16 (a) Informant

Mrs. James Batterdine

(b) Address

1130 Homewood Ave

17 (a) Burial

(b) Date thereof Oct 19, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore

18 (a) Funeral director

Gita Wiedefeld

(b) Address

914 Greenmount Ave

19 (a)

(Date rec'd by Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 734 E. Biddle Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1943 5:25 PM

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions

Cerebral aneurysm

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-15-43 at 4:30 PM

(b) Where did injury occur? Greenmount & Gordon

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Picked up in the street

23. Signature Thomas J. Hulsheis

M.D.

Date signed 10-16-43

19 (b)

(Date rec'd by Registrar)

19 (c)

(Date rec'd by Registrar)

G 09214

BALTIMORE CITY HEALTH DEPARTMENT

G 09214

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 18 1943

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attend-

ed deceased from 10/5/43 to 10/18/43.

and that I last saw her alive on 10/18/43.

Immediate cause of death

Respiratory Death under anesthesia

Due to

Due to

Other Conditions

Carcinoma of Splanic Pleure & colon

(Include pregnancy within 3 months of death)

Date of operation 10/15/43

Major findings of operation: Carc. of colon

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 10/12/43

G 09215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09215

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 858 Washington, Blvd
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MB (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 858 Washington, Blvd
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mary J. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account
No. - - - -

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced
widow

6 (b) Name of husband or wife Alexander Stewart

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Dec 23/1863

AGE:	Years	Months	Days	If less than one day
	79	9	7 23	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

12. Name John Hartman

13. Birthplace Baltimore, Md

14. Maiden Name Ella Swann

15. Birthplace Baltimore, Md

16 (a) Informant Mary Stewart

(b) Address 858 Washington, Blvd

17 (a) Burial (b) Date thereof Oct 20/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson, Ave

18 (a) Funeral director Ambrose Inc

(b) Address 814 N. Franklinton, Rd

19 OCT 18 1943
(Date rec'd by registrar)

Huntington, N. M.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1943 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1943 to Oct. 16 1943, and that I last saw her alive on Oct 16 1943.

Immediate cause of death

Carcinoma of uterus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Harry Leates

23. Signature Harry Leates

Address 517 Acorn St Date signed 10/18/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09216

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 506 W. Franklin St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME DORSEL E PRUITT

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

S

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 - 19438. AGE: Years Months Days
1 19 hr. min.9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John P. Pruitt13. Birthplace Lutley, Kentucky14. Maiden Name Clarence Larnett15. Birthplace Kentucky16 (a) Informant Mr. John P. Pruitt(b) Address 506 W. Franklin St.17 (a) burial (b) Date thereof 10/19/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. AloysiusLocation 2901 Federal Ave18 (a) Funeral director John P. Pruitt(b) Address 906 E. Hollins St.Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 506 W. Franklin St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943 at 10 AM21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Pneumonia, lobular

Due to

Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. H. Wollamater M.D.Date signed 10-18-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09217

09217
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date recorded by Registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Huntington Williams, M.D.

G 09218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09218

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2320 E. Preston St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-03-1767

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Hilda Elizabeth

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

April 15, 1898

8. AGE:

Years

Months

Days

less than one day

45

6

1

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Pusher

11. Industry or business

Bethlehem Steel

FATHER

12. Name

Henry Muller

13. Birthplace

Balto. Md.

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Hilda Elizabeth Muller

(b) Address

2320 E. Preston St

17 (a)

Burial

(b) Date thereof 10-19-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair

18 (a) Funeral director

Phy. C. Miller

(b) Address

2425 E. Oliver St

19 (a)

OCT 18 1943

(b) Huntington, W. Va.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2320 E. Preston St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-16-1943, 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1943 (October 16, 1943).

and that I last saw him alive on October 19, 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Chronic Interstitial Nephritis and Arterial Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Albert C. Cissler

Address 2025 E. North Ave

Date signed

10/16/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH09219
Registered No.1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address 1013 Plum Alley

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2

3 (a) FULL NAME Viola Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Richard Spriggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891 -

8. AGE:

Years 22

Months -

Days -

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

Homemaker

FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Tate

15. Birthplace

Unknown

16 (a) Informant

Auntie Harris

(b) Address

2274 Hamling St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10-19-47

(c) Cemetery or crematory

Baltimore National

Location

Baltimore City

18 (a) Funeral director

Saint L. Brown

(b) Address

108 W. Montgomery St

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1013

Plum Alley

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-14-1948

at

2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1943 to 10-14-1943 and that I last saw him alive on 10-18-1943.

Immediate cause of death

Endocarditis

Due to

Due to

Other Conditions

Cancer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James D. Brown

M. D.

Address

1016 S. Hamp St

Date signed 10-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09220

84234

ya

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 09220

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1894

8. AGE: Years Months Days If less than one day
48 9 18 hr. min.

9. Birthplace N. C.

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
MOTHER

12. Name Franklin Stokes

13. Birthplace N. C.

14. Maiden Name Ellen Spencer

15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 18 1943

18 (a) Funeral director Commissioner of Health

(b) Address
OCT 18 1943 Hunter An Williams, M.D.
(Date of registration) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1943 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1943 to 10/12 1943, and that I last saw him alive on 10/12 1943.

Immediate cause of death

Uremia

Due to

Nephrosclerosis

Due to

A.S. C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

2. L. Sugman

Address

13 CH

Date signed 10/16

Disposition

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09221

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09221

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Bethlehem Steel Co. Fairfield

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *5909 Highgate Drive*

(e) Citizen of foreign country? (If foreign, give location)

If yes, name country

(Yes or No)

3 (a) FULL NAME

*RAYMOND P.**REICHEL DERFER*

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. *218-03-4355*

4. Sex

m

5. Color or race

w

6 (f) Single, married, widowed, or

single

6 (b) Name of husband or wife

ROSE REICHELDERFER

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

JUNE 14- 19 12

8. AGE: Years

Months

Days

If less than one day

*31**4**3*

hr.

min.

9. Birthplace

PENN. PA.

(Town, county, and state)

10. Usual Occupation

SHIP FITTER

11. Industry or business

BETH. STEEL FAIRFIELD

12. Name

WM. REICHELDERFER

13. Birthplace

PENN. PA.

14. Maiden Name

ALICE HOURER

15. Birthplace

PENN. PA.

16 (a) Informant

HARRY REICHLDERFER

(b) Address

*5909 HIGHGATE DRIVE*17 (a) *BURIED*

(Burial, cremation, or removal)

(b) Date thereof

OCT. 22/43

(month) (day) (year)

(c) Cemetery or crematory

ZION LHM. CEM.

Location

PENN. PA.

18 (a) Funeral director

Lilly & Zeller INC.

(b) Address

*403 S. Waverly St.**18 1943*

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct 17*19*43* at *5:45* P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Valvular heart disease**myocardial infarction*

Due to

Rheumatic fever

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature

*H. Z. Wollemuth M.D.*Date signed *10-17-43*

Medical Examiner.

(over)

G 09222

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09222

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 127 Warren Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 127 Warren Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Emma E Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

J Berkley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 23 1924

8. AGE: Years

Months

Days

If less than one day

hr.

min.

69

5

23

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

H 24

11. Industry or business

FATHER

12. Name

Robert Mc Clean

13. Birthplace

Md

MOTHER

14. Maiden Name

Margaret Watchman

15. Birthplace

Md

16 (a) Informant

Mrs Elizabeth Mishkin

(b) Address

127 Warren Ave

17 (a) Burial

(b) Date thereof

10/19/43

(c) Cemetery or crematory

London Park

Location

3901 Frederick Ave

18 (a) Funeral director

William M Mareck

(b) Address

5 Light St

19 (a)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1943, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13/1943, to 10/16/1943, and that I last saw him alive on 10/15/1943.

Immediate cause of death

Coronary thrombosis

Due to

Due to

Other Conditions Hypertensive
cardio vascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Harry Deibel

Address 1226 Hanover St. Date signed 10/17/1943

Duration

4 or

5 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09223		BALTIMORE CITY HEALTH DEPARTMENT		G 09223	
CERTIFICATE OF DEATH 937					
Registered No.					
1. PLACE OF DEATH:					
(a) Baltimore City, Maryland					
(b) Street address 1800 E. Madison St					
(c) Hospital or institution:					
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5					
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years					
2. USUAL RESIDENCE OF DECEASED:					
(a) State Md (b) County					
(c) City or town Balto (If outside city or town limits, write RURAL and give town)					
(d) Street No. 1800 E. Madison St (If rural give location)					
(e) Citizen of foreign country? (Yes or No)					
If yes, name country					
3 (a) FULL NAME Henry G. Schneider					
3 (b) If veteran, name war No					
3 (c) Social Security Account No. No					
4. Sex Male		5. Color or race White		6 (a) Single, married, widowed, or divorced. Widowed	
6 (b) Name of husband or wife Emma Schneider					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, year) June 7 th 1865					
8. AGE: Years 78		Months 4		Days 11	
				hr. min.	
9. Birthplace Marburg - Germany (Town, county and state)					
10. Usual Occupation Retired					
11. Industry or business Tailor					
12. Name Henry Schneider					
13. Birthplace Germany					
14. Maiden Name Marie Schmidt					
15. Birthplace Germany					
16 (a) Informant Mrs Margaret Reifsnider					
(b) Address 800 E. Madison St.					
17 (a) Burial (Burial, cremation, or other) (b) Date thereof 10/21/43 (month) (day) (year)					
(c) Cemetery or repository Parkwood					
Location Parkville Md.					
18 (a) Funeral director William Cook Inc					
(b) Address 1217 St. Paul St.					
19 (a) (Date rec'd by registrar) Oct 19 1943					
(b) Registrar Huntington Williams					
20. DATE OF DEATH Oct 18 th 1943 10 a. M					
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1943, to Oct 17 1943, and that I last saw him alive on Oct 17 1943.					
Immediate cause of death Acute Cor. failure					
Due to Ch. Myocarditis					
Due to Coronary atherosclerosis					
Other Conditions:					
(Include pregnancy within 3 months of death)					
Date of operation:					
Major findings of operation:					
of autopsy:					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at M					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?					
(e) Means of injury					
23. Signature A. H. Hornstein					
Address 733 Lexington St					
Date signed 10/18/43					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

G 09224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09224
Registered No. 83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 832 S. Bond St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Lena Hansford

3 (b) If veteran, name war

NU

3 (c) Social Security Account

No. 10 10 10

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Widowed

6 (b) Name of husband or wife

Emmett C. Hansford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 5 - 1892

8. AGE:

Years

Months

Days

If less than one day

51 50

8

12

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Seamstress

11. Industry or business

Self

12. Name

Fredrick Mack

13. Birthplace

Germany

14. Maiden Name

Melina Gast

15. Birthplace

Mrs. Thomas Bailey

16 (a) Informant

Mrs. Thomas Bailey

(b) Address

344 S. Robinson St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 10/20/43

(c) Cemetery or crematory

Oak Grove

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a)

(Date of death)

Oct. 19 1943

Registrar

Huntington Williams, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Balto.

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

832 S. Bond St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 17 1943 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1943 to 10/17 1943

and that I last saw her alive on 10/16 1943

Immediate cause of death

Cerebral
hemorrhage

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Charles Stone

Address

3215 Eastern Ave

Date signed 10/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Tb

G 09225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09225
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2211 Rogers Ave

(c) Hospital or institution:

Home for Aged, M.E. Shunk

(d) Length of stay in hospital or inst. (yrs., mos., or days)

2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2211 Rogers Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emily Everist

3 (b) If veteran, name war

NO

(c) Social Security Account

No. 1-1-1-1

4. Sex

Female

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Thomas Everist

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 26, 1858

8. AGE:

Years

Months

Days

less than one day

85

1

20

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Easton J. Sparklin

13. Birthplace

Cassidy & Co. MD

MOTHER

14. Maiden Name

Beth Mott

15. Birthplace

Baltimore, MD

16 (a) Informant

Marion J. Coates

(b) Address

2211 Rogers Ave

17 (a) Burial

10/19/43

(b) Date thereof

(c) Cemetery or crematory

London Park

(d) Location

Baltimore, MD

18 (a) Funeral director

William C. Lee

(b) Address

1517 N. 1st St.

(c) Date rec'd by registrar

10/16/43

(d) Signature

William C. Lee

(e) Address

800. 2332

(f) Date signed

10-16-43

(g) Registrar

William C. Lee

(h) Signature

William C. Lee

(i) Address

800. 2332

(j) Date signed

10-16-43

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 16

1943, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended

deceased from Sept 15, 1943, to Oct 15, 1943,

and that I last saw her alive on Oct 15, 1943.

Immediate cause of death

Myocardial insufficiency

Due to arterio sclerosis

Duration 40 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature

Arthur J. Davis

Address

800. 2332

Date signed

10-16-43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09226

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09226
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1339 W. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Thomas Henry Watts

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-12-6044

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband's wife Viola Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 24th 1890

8. AGE:

Years

Months

Days

If less than one day

53

4

23

hr.

min.

9. Birthplace

Balto. Md.

10. Usual Occupation

Firmman

11. Industry or business

Bethlehem Fairchild Co.

12. Name

Thomas H. Watts

13. Birthplace

Balto. Md.

14. Maiden Name

Isabelle Donnelly

15. Birthplace

Balto. Md.

16 (a) Informant

James T. Watts

(b) Address

408 Pittman Place

17 (a) Burial

(b) Date thereof

10/20/43

(c) Cemetery or crematory

Cathedral

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1317 St. Paul St.

(c) Address

Huntington Williams

(d) Address

1317 St. Paul St.

(e) Address

Huntington Williams

(f) Address

Huntington Williams

(g) Address

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No.

1339 W. North Ave
(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1943 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1943, to Oct 17 1943 and that I last saw him alive on Oct 15 1943.

Immediate cause of death

Coronary Thrombosis
Due to Myocardial Insufficiency

Duration

Immediate

Due to Chronic Bronchitis

6 years

10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

G. T. Bellup

M. D.

Address 2224 W. North Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09227

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09227
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *3216 O'Donnell St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *26*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Katherine Wodalo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female White Widowed

6 (b) Name of husband or wife

Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE:

Years

Months

Days

If less than one day

61

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Joseph Berazowski

13. Birthplace

Poland

MOTHER

14. Maiden Name

Raniecki

15. Birthplace

Poland

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Oct. 21/43*

(month) (day) (year)

(c) Cemetery or crematory

Sacred Heart of Mary

Location *Baltimore*

18 (a) Funeral director

Fred W. Gzazowski

(b) Address

900 Eastern Ave

19 (a)

OCT 19 1943

VS 150

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. *3216 O'Donnell*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 17

19*43* at

M

21. I certify that death occurred on the date above stated; that I attended deceased from *July 1* 19*43*, to *Oct 17* 19*43*, and that I last saw her alive on *Oct 16* 19*43*.

Immediate cause of death

Carcinoma of Gall Bladder

a metastasis to liver.

Due to

Due to

Other Conditions

none

(Include pregnancy within 3 months of death)

Date of operation

Aug 5, 1943.

Major findings of operations:

same as above.

of autopsy:

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

none

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. Schumacher

M. D.

Address

842 E. N. Ave

Date signed *10-18-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1844 W. 20
G 09228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09228

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2010 Baker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2010 Baker St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROTH SHERB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female White

5 Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1919

8. AGE: Years 24 Months 3 Days 11 min. If less than one day

9. Birthplace New York City

10. Usual Occupation None

11. Industry or business

12. Name Sam Sherb

13. Birthplace Russia

14. Maiden Name Mary Katz

15. Birthplace Russia

16 (a) Informant Sam Sherb Father

(b) Address 2010 Baker St.

17 (a) Burial (b) Date thereof 10-19-43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Terapany Hill Rd.

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1439 E. Balt St.

19 (a) OCT 19 1943 (b) (Day, month, year)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-43 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1943 to Oct 18 1943, and that I last saw her alive on Oct 18 1943.

Immediate cause of death Chronic valvular heart disease Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Louis P. Levy Date signed 10/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09229
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

PATRICK TURNER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

MALE WHITE

Single

6 (b) Name of husband or wife

July 15 - 1942

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

1

143

3

hr

min.

9. Birthplace:

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER: FATHER:

12. Name

PATRICK TURNER

13. Birthplace

Md

14. Maiden Name

Catherine Lewis

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof

Oct 19/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Mary's

Location

Annapolis

18 (a) Funeral director

D. L. Hopkin

(b) Address

Annapolis

19 (a)

OCT 19 1943

(b)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Balt.

(c) City or town

Middle River

(If outside city or town limits, write RURAL and give town)

Street No.

2 Manfred Ct. Victory Village

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 18

1943. at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1943 to Oct 18 1943, and that I last saw him alive on Oct 18 1943.

Immediate cause of death

Circulatory failure

Due to

Meningitis

Due to

Influenza

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. Lee Randol

Address

John Hopkins Hospital

M.D.

signed 10/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09230
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Pato

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1615 Jewellyn Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Nancy Cale

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

F

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 15 1943

8. AGE: Years Months Days If less than one day

8 2 hr. min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER
MOTHER

12. Name CLAYBORN W. CALE

13. Birthplace VA.

14. Maiden Name BULUAH ROSS

15. Birthplace VA.

16 (a) Informant CLAYBORN CALE (FATHER)

(b) Address 1615 JEWELLYN AVE.

17 (a) BURIAL (b) Date thereof OCT. 21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory CRAGESVILLE CEM.

Location CRAGESVILLE VA.

18 (a) Funeral director Lilly and Jailer INC.

(b) Address 403 S. WOLFE ST.

19 (a) OCT 19 1943 (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-43 19 at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-43 3:30 PM to 10-17-43 5:40 PM and that I last saw her alive on 10-17-42 19

Immediate cause of death

Dehydration

Due to Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Kyanosine

Address St. Joseph's Hosp Date signed 10-18-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09231		BALTIMORE CITY HEALTH DEPARTMENT		G 09231	
PLACE OF DEATH:		CERTIFICATE OF DEATH 52B			
(a) Baltimore City, Maryland		2. USUAL RESIDENCE OF DECEASED:			
(b) Street address 2801 BRENDEN AVE.		(a) State MD. (b) County BALTO.			
(c) Hospital or institution:		(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)			
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(d) Street No. 2801 BRENDEN AVE. (If rural give location)			
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS.		(e) Citizen of foreign country? (Yes or No) If yes, name country			
3 (a) FULL NAME		MEDICAL CERTIFICATION PM.			
CATHERINE BRAY		20. DATE OF DEATH OCT. 16 19 43 at 7/50M			
3 (b) If veteran, name war		21. I certify that death occurred on the date above stated; that I attend-			
NO		ed deceased from 1/1/43 19 10/16/43.			
3 (c) Social Security Account		and that I last saw K. alive on 10/16/43.			
No. NONE		Immediate cause of death			
4. Sex		Carcinoma Bladder 2 yrs			
5. Color or race		Due to			
FEMALE WHITE		Due to			
6 (a) Single, married, widowed, or divorced.		Other Conditions none			
WIDOW		(Include pregnancy within 3 months of death)			
6 (b) Name of husband or wife		Date of operation			
MICHAEL BRAY		Major findings of operation:			
6 (c) If alive, give age years		of autopsy			
7. Birth date of deceased (mo., day, yr.) MAR. 5 1879		22. If death was due to external causes, fill in the following:			
8. AGE: Years Months Days If less than one day		(a) Accident, suicide, or homicide			
64 7 11 hr. min.		(b) Date of occurrence at M			
9. Birthplace IRELAND		(c) Where did injury occur? (City or town) (County) (State)			
(Town, county, and state)		(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
10. Usual Occupation HOUSE WIFE		(e) Means of injury			
11. Industry or business AT HOME		23. Signature T. J. Williams M.D.			
12. Name DANIEL GEORG		Address 1710 E 32 Date signed 10/19/43			
13. Birthplace IRELAND					
14. Maiden Name MARY SMITH					
15. Birthplace IRELAND					
16 (a) Informant MARY FOERETH (DAUGHTER)					
(b) Address 2801 BRENDEN AVE.					
17 (a) BURIAL (b) Date thereof OCT. 20/43					
(Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory NEW CATHEDRAL					
Location OLD FREDERICK ROAD					
18 (a) Funeral director Lilly and Giller INC.					
(b) Address 403 S. WOLFE ST.					
19 (a) Huntington Williams M.D.					
Date signed OCT 19 1943					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09232

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09232

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2117 GOUGH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 GOUGH ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN T. LEWIS

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife BRIDGET M. LEWIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 19 1871

8. AGE: Years Months Days If less than one day

72 71 6 28 27 hr. min.

9. Birthplace BALTIMORE MD?

(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

12. Name REDMAN LEWIS

13. Birthplace IRELAND

14. Maiden Name JOHANNA McDONALD

15. Birthplace IRELAND

16 (a) Informant JOHANNA LEWIS (WIFE)

(b) Address 2117 GOUGH ST.

17 (a) BURIAL (b) Date thereof OCT. 20/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Giles INC

(b) Address 403 S. WOLFE ST.

19 (a) (b)

(Date rec'd by registrar)

Registrar

19 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH OCT. 16 19 43 at 8/25M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 1, 1943 to Oct. 16, 1943, and that I last saw him alive on Oct. 16, 1943.

Immediate cause of death

myocarditis (chronic)

Duration

3 mos.

Due to arteriosclerosis
and Diabetes mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Engine R. Person

23. Signature

Engine R. Person M. D.
Address 514 Drury Lane Date signed 10/18/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 G 09233
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 604 S. ROBINSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIF E

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S. ROBINSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

MARY LEIKAM

3 (b) If veteran, name war NO 3 (c) Social Security Account No. NONE

4. Sex FEMALE 5. Color or race WHITE 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife JOSEPH LEIKAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 26 1861

8. AGE: Years 81 Months 11 Days 21 20 hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JOSEPH OTT

13. Birthplace GERMANY

14. Maiden Name MARGARET PALAUS

15. Birthplace GERMANY

16 (a) Informant ROSE LEIKAM (DAUGHTER)

(b) Address 604 S. ROBINSON ST.

17 (a) BURIAL (b) Date thereof OCT. 20/4 3
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler INC

(b) Address 403 S. WOLFE ST.

19 (a) (b) For Williams, M.D.

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH OCT. 16 1943 4/10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1943 to Oct. 16 1943, and that I last saw her alive on Oct. 15 1943.

Immediate cause of death Hyperextension of spine
Arteriosclerosis of brain

Due to myocardial failure
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations None

of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Schumacher M. D.

Address 842 S. Enoch Ave Date signed 10-16-43

Duration

Sept 16/43
Oct 16/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *42 YRS*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *811 S. Broadway*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME *MICHAEL HANLON*

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug. 15, 1884*8. AGE: Years *58* Months *2* Days *2*
If less than one day hr. min.9. Birthplace *Ireland*
(Town, county, and state)10. Usual Occupation *Shipyard worker*

11. Industry or business

12. Name *?*13. Birthplace *?*14. Maiden Name *?*15. Birthplace *?*16 (a) Informant *Sayde Stamalelos - friend*(b) Address *811 S. Broadway*17 (a) *BURIAL* (b) Date thereof *OCT. 19/4*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *SACRED HEART*Location *GERMAN HILL ROAD*18 (a) Funeral director *Lilly and Geiler INC.*(b) Address *403 S. WOLFE ST.*19 (a) *OCT 10 1948* (b) *Huntington Williams M.D.*
(Made valid by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 17 1948, at 6:45 PM*21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Arteriosclerosis**Cardiovascular*Due to *degenerative*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature *H. Z. Wollenmuth* M.D.Date signed *10-18-48* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09235

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 611½ N. Bethel St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 611½ N. Bethel St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lillie M. Cornish

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

Col.

Married

6 (b) Name of husband or wife Nathaniel Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1900

8. AGE: Years Months Days If less than one day
43 5 1 hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph Smith

13. Birthplace Md.

14. Maiden Name Sarah Wolford

15. Birthplace Md.

16 (a) Informant James H. Cornish

(b) Address 613 N. Dallas St.

17 (a) Burial (b) Date thereof 10/19/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

OCT 19 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1943 at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1943 at Oct. 16 1943 and that I last saw h.c.k. alive on Oct. 16 1943

Immediate cause of death

Cerebral Hemorrhage
Due to Hypertensive Condition
with Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ralph W. Beckling

Address 426 N. Eymore Date signed 10/18/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09236

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 111 N Wolfe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 111 N Wolfe
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country Austria

3 (a) FULL NAME

Sophia L. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Albin Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1873

8. AGE: Years 70 Months 9 Days 16 If less than one day
hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Patrick Fessler

13. Birthplace Austria

14. Maiden Name Dont Kun

15. Birthplace Austria

16 (a) Informant Mrs Stella Novier

(b) Address 19223 Garrison

17 (a) Burial (b) Date thereof Oct 21
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem
Location Rural

18 (a) Funeral director William Fessler

(b) Address 2004 E. Orleans St

19 (a) Oct 19 1943 Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1943 to Oct 18 1943 and that I last saw him alive on Oct 18 1943

Immediate cause of death
General Atherosclerosis
Chor Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
While at work? _____
(Specify type of place)

(e) Means of injury

Signature Myron L. Solomon

Address 129 S. Broadway Date signed 10/19/43

Duration

1 yr
1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09238

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09238

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert Sts.

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland

(b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2945 Keswick Road, City

(If rural give location)

(e) Citizen of foreign country? No

If yes, name country

3 (a) FULL NAME

Daniel Louis Calp

3 (b) If veteran, name war

3 (c) Social Security Account

No. 71-801-8759

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 26, 1881

8. AGE:

Years

Months

Days

If less than one day

62

3 mos.

21

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Boiler Maker

11. Industry or business

FATHER

12. Name

John Calp

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Mary Roebuck

15. Birthplace

Maryland

16 (a) Informant

Medical Chart

(b) Address

17 (a) Burial

(b) Date thereof

Oct 20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Bethelville

Location

Balto 150, Md.

18 (a) Funeral director

Chenoweth & Sonoran

(b) Address

3615-17 Chestnut Ave.

19 (a)

OCT 19 1943

for Williams, M.D.

(Date and by whom signed)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1943, 6:13 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1943, to Oct. 17 1943, and that I last saw him alive on Oct. 17 1943.

Immediate cause of death Cardio-respiratory failure

Duration

Due to Broncho-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address Union Mem. Hosp.

M.D.

Date signed Oct 19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09239

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Caton & Wilkins Ave.*
(c) Hospital or institution: *St. Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *13*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *850 Power St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Catherine P. Tracy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Clarence M. Tracy*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb 18, 1885*

8. AGE: Years Months Days If less than one day

58 *8* *-* hr. min.

9. Birthplace *Maryland*

(Town, county, and state)

10. Usual Occupation *Homemaker*

11. Industry or business

12. Name *Armenia Wickens*

13. Birthplace *Maryland*

14. Maiden Name *Unknown*

15. Birthplace *Unknown*

16 (a) Informant *Robert Tracy*

(b) Address *3623 Chestnut Ave.*

17 (a) *Burial* (b) Date thereof *Oct 21/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Agnes*

Location *Baltimore, Md.*

18 (a) Funeral director *Chenoweth & Sonoran*

(b) Address *3615-17 Chestnut Ave.*

19 (a) *OCT 19 1943*

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/18/43* at *6:30 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *8/30/43* to *10/18/43*, and that I last saw her alive on *10-18-43*.

Immediate cause of death

*Primary carcinoma of the gall bladder
with metastasis to the liver*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *9/14/43*

Major findings of operations: *Carcinoma of the gall bladder & metastasis*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *W. H. Harrison*

Address *St. Agnes Hosp* Date signed *10/18/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Caution - In completing this form, please write the causes of death clearly and legibly.

09240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09240
Registered No.

1. CAUSE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Ogston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town B
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Ogston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Sneed
3 (b) If veteran, name war 3 (c) Social Security Account No. 218-03-0292
4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Myrtle F. Sneed 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 27, 1897
8. AGE: Years 46 Months - Days 20 If less than one day hr. min.
9. Birthplace Henderson N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
12. Name James Sneed
13. Birthplace Henderson N. C.
14. Maiden Name Elizabeth Swinetslett
15. Birthplace Henderson N. C.
16 (a) Informant Myrtle Sneed
(b) Address 508 Ogston St
17 (a) Burial (b) Date thereof Oct 20-43 (month) (day) (year)
(c) Cemetery or crematory Henderson
Location Henderson N. C.
18 (a) Funeral director Mrs. Kate P. Williams
(b) Address 322 N. Schroeder St
19 OCT 19 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1943 at 7:00 AM
21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were: IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature Robert L. Graham M.D.
Date signed Oct. 19 1943

VS 181

G 09241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09241

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) d. 2. a. 2.
 (e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1146 E. Lombard Street
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

JAMES ROBERT HARRISON

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr) June 1, 1943

8. AGE: Years _____ Months 4 Days 17 If less than one day
 hr _____ min. _____

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

12. Name Robert Harrison
 13. Birthplace Portsmouth, Va.

14. Maiden Name Elizabeth Perry
 15. Birthplace Portsmouth, Va.

16 (a) Informant Elizabeth Harrison
 (b) Address 1146 E. Lombard Street

17 (a) Burial (b) Date thereof Oct 20 1943
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
 Location W. A. Canal

18 (a) Funeral director Robert M. Knight
 (b) Address 721 Chesapeake St

19 (a) OCT 19 1943 (b) Huntington Williams, M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 19 43, at 11:20 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxiation due to aspiration of vomitus.

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury Henry L. Wollenweber, M.D.

23. Signature _____ M.D.

Date signed 10-19-43 Medical Examiner.Prof. Howard J. Williams, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09242

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09242
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland
Baltimore, Md.

(b) Street address

(c) Hospital or institution:

West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.b.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

EVA SAUERS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Widow

6 (b) Name of husband or wife William Sauers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1855

8. AGE: Years Months Days 13 If less than one day

88

2

12

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Home

11. Industry or business

FATHER
MOTHER

12. Name Andrew Germuth

13. Birthplace Germany

14. Maiden Name Anna E. Wickeser

15. Birthplace Baltimore, Md.

16 (a) Informant Joseph A. Derreth

(b) Address 1810 Edmondson Avenue

17 (a) Burial (b) Date thereof 10/20/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Mrs. Hahn & Son

(b) Address 2503 Edmondson Ave

19 (a) OCT 19 1843

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1810 Edmondson Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1943, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Intracranial hemorrhage.

Diabetes mellitus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of
death, fill in the following:

(a) Date of injury Oct. 17, 1943; 7:45 P.M.

(b) Where did injury occur? 1810 Edmondson Avenue

(c) Did injury occur at home, on farm, industrial place, in public
place? Home While at work? No

(d) Means of injury Fell down the steps of her home.

23. Signature Henry L. Wollenweber, M.D.M.D.

Oct 19, 1943 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09243
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Denison St.,

(c) Hospital or institution:

Brawford Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore,

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1335 Poplar Grove St.,

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Ernestine Lancaster

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4 Sex Female

5 Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Samuel J. Lancaster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1855

8. AGE: Years 88 Months 1 Days 19 20 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

12. Name Wm. Woodward Franks

13. Birthplace Va.

14. Maiden Name Mary Rose Simpson

15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Gallehue

(b) Address 1335 Poplar Grove St.,

17 (a) Burial (b) Date thereof Oct. 20, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.,

18 (a) Funeral director J. Howard Strong

(b) Address 3207 W. North Ave.,

19 OCT 19 1943 (Date of death) Huntington Williams, M.D. (Physician)

MEDICAL CERTIFICATION 12.01

20. DATE OF DEATH Oct. 17, 1943 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Oct 17 1943 and that I last saw him alive on Oct 16 1943

Immediate cause of death Acute Sclerosis

Due to Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. Strong

Address 677 N. Zimble Date signed 10/19/43

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

09244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09244

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
Baltimore City Hospitals
 (d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 610 South East Avenue
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME
MICHAEL JAMES McDONOUGH

3 (b) If veteran, name war
 3 (c) Social Security Account
No. 097-05-9291

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 20, 1893

8. AGE: Years 50 Months 51 Days 5 If less than one day
28 hr. min.

9. Birthplace New York City
 (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Sparrows Point

FATHER 12. Name Michael McDonough
 13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine O'Neill
 15. Birthplace Ireland

16 (a) Informant SADIE Sadie McDermott

(b) Address 70 Washington St., Hoboken, N.J.

17 (a) Burial (b) Date thereof 10-22-43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Name Cemetery
 Location Hoboken N.J.

18 (a) Funeral director A. Lee Adler

(b) Address 46 44 York Rd.
Thornhill, N.J.

19 (a) 19-19-43 (b) 0
 (Date of death) (Registrar)

VS 151 (OVER)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1943 at 11:35 A. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was IMMEDIATE CAUSE OF DEATH
Coronary occlusion.

Due to
 Other Conditions
 (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
 (b) Where did injury occur?
 (c) Did injury occur at home, on farm, industrial place, in public place? While at work?
 (d) Means of injury Henry L. Wollenweber, M.D.

23. Signature Dr. Howard J. ... M.D.
 Date signed 10-19-43 Medical Examiner

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Belmont & Belvedere

(c) Hospital or institution:

Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Balto. City

(c) City or town

Balto. City

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3031 Guyman Falls Hwy.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Alexander James M^c Kerich

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4 Sex

Male

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Caroline H. M^c Kerich

6 (c) If alive, give age

4 years

7. Birth date of deceased (mo., day, yr.)

March 30, 1873

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

70

6

17

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual Occupation

Retired Nurse, Steamship

11. Industry or business

C. of P. R. R.

FATHER
MOTHER

12. Name

Alex. J. M^c Kerich

13. Birthplace

Scotland

14. Maiden Name

Not known

15. Birthplace

"

16 (a) Informant

Mrs. Caroline H. M^c Kerich

(b) Address

3031 Guyman Falls Hwy - City

17 (a)

Burial

(b) Date thereof

Oct. 20, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park

Location

Balto., Md.

18 (a) Funeral director

STEWART & MOWEN COMPANY

(b) Address

(W. F. WOODEN BLDG.) 100 W. NORTH AVENUE

19 (a)

OCT 19 1943

Huntington Williams, M.D.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1943, at 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/43, 19, to 10/12/43, 19.

and that I last saw him alive on 10/12/43, 19.

Immediate cause of death

Cerebral Vascular Accident

Due to

arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Francis W. Gluck

Address 715 Park Ave

Date signed

M. D.

10/18/43

GLUCK

99246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09246
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *314 1/2 Charles St.*

(c) Hospital or institution:

Home (Homewood Apts.)

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *15-20 yrs.*

3 (a) FULL NAME

Mrs Frances Ridgely von Ruesen

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4 Sex

Female

5. Color of face

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

SAMUEL VON RIESEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr. 20 1861

8. AGE:

Years

82

Months

5

Days

27

If less than one day

hr.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

None

FATHER

12. Name

Charles D. Ridgely

13. Birthplace

Balt. Co., Md.

MOTHER

14. Maiden Name

Mary Louise Hopper

15. Birthplace

Baltimore, Md.

16 (a) Informant

Miss Evelyn R. Ruesen (Niece)

(b) Address

*Lutherville, Balt. Co., Md.*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Oct. 19 - 1943

(c) Cemetery or crematory

Green Mount

Location

Balt. Md.

18 (a) Funeral director

STEWART & MOWEN COMPANY

(b) Address

(W. F. WOODEN BLDG.) 100 W. NORTH AVENUE

OCT 19 1943

(Date of death)

(b) *Huntington Williams, M.D.*

(Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balt. City

(d) Street No.

314 1/2 Charles St.

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

No

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct 17 1943*Time *3 a.m.*

21. I certify that death occurred on the date above stated, that I attended

deceased from *Mich 1 1943 to Oct 17 1943*and that I last saw him alive on *Oct 15 1943*

Immediate cause of death

*Cerebral Haemorrhage?*Due to *Arterio Sclerosis about 15 yrs*Due to *To My knowledge 12/20*Other Conditions *Very High Blood Pressure*

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature *P. L. Keyser*Address *W. F. WOODEN BLDG.*Date signed *Oct 17 1943*

KEYSER

G 09247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09247

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1802 N. Lexington*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife *E. Corrado Cook*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years *78* Months *5* Days *17* At less than one day9. Birthplace *St. Michaels, Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address *1802 N. Lexington*

17 (a) Burial, cremation, or removal

(b) Date thereof *10/20/43*
(month) (day) (year)

(c) Cemetery or place of interment

Location *Stephensonville, Md.*

18 (a) Funeral director

(b) Address *1300 E. Pratt St.*(c) Date of death *19/19/43* *Huntington, Williams, Md.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1802 N. Lexington St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/17/43* *3:30 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *10/5* *1943* to *10/17* *1943*, and that I last saw him alive on *10/17* *1943*.

Immediate cause of death

*Stroke - Hemorrhage*Due to *hypertension*Due to *Arterio Sclerosis*Other Conditions *Diabetes Mellitus*
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Samuel K. Gibson*Address *724 Theodora Ave.* Date signed *10/19/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED FOR FILING

09248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G 09248
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 2508 Southern Ave
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 27
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL, and give town)
 (d) Street No. 2508 Southern Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Medred R. Aymond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Bernard Aymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 1862

8. AGE: Years Months Days If less than one day

81

2

15

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name William Mater

13. Birthplace Ireland

14. Maiden Name Agnes Redmond

15. Birthplace Ireland

16 (a) Informant Mrs B Russell

(b) Address 2508 Southern Ave

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof 10/20/43

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

18 (a) Funeral director J. J. J. J. J.

(b) Address 318 Light St.

19 (a) Date of death OCT 19 1943

(b) Signature of physician

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1943. 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1943 to Oct 17 1943 and that I last saw him alive on Oct 16 1943.

Immediate cause of death

Carcinoma of uterus (cancer)

Due to

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature George Sawyer

Address 4808 Harford Rd.

Date signed 10/18/43

Duration

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09249

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1200 Valley Street

(c) Hospital or institution:

Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary Billups

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1863

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name

Archibald McDonald

13. Birthplace

?

MOTHER

14. Maiden Name

Mary M. Cashen

15. Birthplace

?

16 (a) Informant

Little Sisters of the Poor

(b) Address

1200 Valley Street Baltimore

17 (a)

Burial

(b) Date thereof

Oct 20, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore

18 (a) Funeral director

Rita Wiedefeld

(b) Address

914 Greenmount Ave

19 OCT 19 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1200 Valley Street

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 17

1943

8 am

at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943. to Oct 17 1943. and that I last saw her alive on Oct 15 1943.

Immediate cause of death

Edema Lungs

Due to

Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. Gell Hall

Address

16318 North Ave

Date signed

Oct 17 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Lee

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex F 5. Color or race C 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1940

8. AGE: Years 2 Months 11 Days 9 If less than one day hr. min.

9. Birthplace Wantedo N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Lee

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Beatrice Lee

15. Birthplace Wantedo N.C.

16 (a) Informant Beatrice Lee

(b) Address 417 N. Gilmore St.

17 (a) Burial (b) Date thereof Oct 19, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Location Norfolk Va.

18 (a) Funeral director Mrs. Walter R. Williams

(b) Address 222 N. Lombard St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1943, at 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Infantile
depression
respiratory tract infection

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.

Date signed Oct. 17 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G 09251
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

229 N. Schroeder St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Bartha Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Charles Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1895

8. AGE:

Years

Months

Days

If less than one day

48

-

23

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

William Taylor

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Hellie ?

15. Birthplace

Baltimore, Md.

16 (a) Informant

Joseph Marshall

(b) Address

229 N. Schroeder St

17 (a)

Burial, cremation, or removal

(b) Date thereof

Oct. 19, 1943

(c) Cemetery or crematory

Arbutus Memorial

Location

18 (a) Funeral director

Miss Katherine R. Williams

(b) Address

322 N. Schroeder St

OCT 19 1943

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

229 N. Schroeder St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-16-43

19

5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6-1943 to 10-16-1943 and that I last saw him alive on 10-16-1943.

Immediate cause of death

Cerebral Hemorrhage

Duration 3 days

Due to

Due to

Other Conditions

Hypertension

3 wks.

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

George C. Page

Address

1516 N. Mount St

Date signed

10-18-43

09252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09252
Registered No.

830

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 722 W. Saratoga St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 5

3 (a) FULL NAME

Clarence Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-09-7386

4. Sex

m

5. Color or race

col

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Ella Spriggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1893

8. AGE:

Years

Months

Days

If less than one day

3-0

2

9

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

Dept. Store

FATHER

12. Name

James Spriggs

13. Birthplace

Calvert Co., Md.

MOTHER

14. Maiden Name

Carrie

15. Birthplace

Calvert Co., Md.

16 (a) Informant

Ella Spriggs

(b) Address

722 W. Saratoga St

17 (a)

Burial

(b) Date thereof

Oct 21, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Zion Cem

Location

18 (a) Funeral director

Mrs. Kate P. Williams

(b) Address

1010 N. E. St.

19 (a)

Date rec'd by registrar

Oct 19, 1943

Registrar

VB 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give location)

(d) Street No. 722 W. Saratoga St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-43 1943 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22-1943 to 10-6-1943, and that I last saw him alive on 10-16-1943.

Immediate cause of death

Cerebral Hemorrhage

Duration

2 days

Due to

Hypertension

Due to

Other Conditions

Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1516 N. Mount Date signed 10-18-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09253

JL- 84243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 09253

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

4940 Eastern Ave.

(b) Street address

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 589 Oxford Ct.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Linwood Tillery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Priscilla

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1891

8. AGE: Years

52

Months

8

Days

13

If less than one day

hr

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden Name Nancy

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Oct. 29, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Hollinsworth St

19 (a) OCT 10 1943 Huntington Williams, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-15

1943 at 1:20 P

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1943 to 10/16 1943 and that I last saw him alive on 10/15 1943.

Immediate cause of death

coronary occlusion; embolus to brain
Due to A-S. S.V. disease & myocardial

Due to

Duration

3

?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

left coronary occlusion, embolus to brain, coronal infarction, left ventricular hypertrophy, atherosclerosis, left ventricular failure

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. L. Sargman

Address

15 C H

Date signed 10/18

G 09254

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09254
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1731 W. North Ave.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARGARET E. TOWSON

3 (b) If veteran, name war none 3 (c) Social Security Account No. none

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joshua J. Towson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1879

8. AGE: Years Months Days If less than one day
63 11 14 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name William Kraft

13. Birthplace Baltimore, Md.

14. Maiden Name Sarah V. Lynch

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Joshua L. Towson

(b) Address 1731 W. North Ave.

17 (a) Burial (b) Date thereof 10/21/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

001-19-1543 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1943 at 3:55AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1943, to Oct. 18, 1943, and that I last saw her alive on Oct. 16, 1943.

Immediate cause of death 1) - Bronchial thrombosis Duration 12 hours

Due to -

Other Conditions Angina Pectoris 4 days
(2) Diabetes Mellitus? PHYSICIAN

Date of operation done

Major findings of operation: Underline the cause to which death should be charged statistically.

of autopsy: - done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Carl L. Chambers M. D.

Address 4108 - Liberty St. Date signed 10/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Dr. Lutz / Temple Sorden Apt
Registered No. 46B
State & County

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 E. 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 729 E. 20th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Lawrence Lutz
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Lola Lutz
6 (c) If alive, give age 18 6-8

7. Birth date of deceased (mo., day, yr.) Mar 3, 1869
8. AGE: Years 75 4-6 Months 7 Days 14 If less than one day hr. min.

9. Birthplace 13 altman
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER 12. Name George H. Lutz
13. Birthplace Bavaria

MOTHER 14. Maiden Name Sarah Heidler
15. Birthplace Penna

16 (a) Informant Mrs Lola Lutz
(b) Address 729 E 20th Street

17 (a) Burial (b) Date thereof Oct 20-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory new Cathedral
Location

18 (a) Funeral director Leonard G. Ruck
(b) Address 5305 Halford Road

(c) Date of death Oct 19 1943 (b) Huntingdon Hills, Md

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct 17 1943 at 99 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 17 1943, and that I last saw him alive on Oct 16 1943.

Immediate cause of death
Intestinal obstruction
Due to general abdominal
Carcinomatous.
Due to Carcinoma of stomach
Other Conditions

Duration
3 day
3 mos.
1 year

(Include pregnancy within 3 months of death)
Date of operation April 18-43
Major findings of operation: Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury
23. Signature J Frederick Lutz
Address Temple Sorden Apt Date signed Oct 18-43 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09256

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1522 N. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1522 N. Lexington St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sadie Cox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Jesse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 13, 1883

8. AGE: Years

Months

Days

If less than one day

60

9

3

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Edmond Liggins

13. Birthplace

Md

MOTHER

14. Maiden Name

Harriet Crowley

15. Birthplace

Md

16 (a) Informant

Jesse Cox

(b) Address

1522 N. Lexington St.

17 (a)

Burial

(b) Date thereof

Oct 19, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arbutus M. Park

Location

Arbutus, Md.

18 (a) Funeral director

Mrs. Robert G. Ellinger

(b) Address

129 N. Caroline St.

19 (a)

Date of death

(b)

Huntington Williams, M.D.

(Date of death)

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-16-

19

at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19, 1939, to 10-16-1943

and that I last saw him alive on March 15, 1943.

Immediate cause of death

Due to

Myocardial Failure

Due to

Other Conditions

Coronary Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Huntington Williams

Address

312 E. 23rd St.

Date signed 10-18-43

affirmed by Harrison J. Wessels, M.D.

OCT 19 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

442991-09257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09257

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ga.** (b) County(c) City or town **Springfield**
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mae Beatrice Altman

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **3/17/27**8. AGE: Years Months Days If less than one day
16 2 2 hr. min.

9. Birthplace

Ga.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Horace J. Altman**13. Birthplace **S. C.**14. Maiden Name **Beatrice Mae Oglesby**15. Birthplace **Ga.**

16 (a) Informant

(b) Address

17 (a) **Burial** (b) Date thereof **Oct 2/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Springfield, Ga**
Location18 (a) Funeral director **John O. Mitchell & Sons**(b) Address **1900 Canton Place**19 (a) (b)
(Date rec'd by registrar)**Huntington Williams, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 19 1943** **10 40 M**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 16 1943** **Oct 19 1943**, and that I last saw her alive on **Oct 19 1943**

Immediate cause of death

Brain tumor - glioma - malignant

Duration

3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **10-18-43**Major findings of operation: **Supratentorial****Tumor**of autopsy: **not done**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **J. N. H.**Address **J. N. H.**Date signed **10/19/43**

OCT 19 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16-09258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09258

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Baby Boy Wilkins, Kenneth Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1943

8. AGE: Years Months Days If less than one day

10

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name of Father E. Wilkins

13. Birthplace Balto. Md.

14. Maiden Name Lillian E. Smith

15. Birthplace Balto. Md.

16 (a) Informant Boulden E. Wilkins

(b) Address 3004 Ellerslie Ave

17 (a) Burial (b) Date thereof Oct. 19-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Arkville

18 (a) Funeral director William Cook Inc.

(b) Address 217 St. Paul St.

OCT 10 1943

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3004 Ellerslie Ave

(e) Citizen of foreign country? (If rural give location)

If yes, name country (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1943 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 PM Oct 18 1943, until 4 PM Oct 19 1943, and that I last saw him alive on Oct 18 1943

Immediate cause of death

Respiratory Failure

Due to Pneumonia

Due to Hemorrhagic Diarrhea

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia, Hemorrhagic Diarrhea

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Hugh H. Power

Address 11. Memorial Hosp Date signed 10/19/43

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09259
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3210 Windsor Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

3 (a) FULL NAME

Agnes S. Cuyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward G. Cuyler

6 (c) If alive, give age - - - years

7. Birth date of deceased mo., day, yr Jan. 1, 1867

8. AGE: Years Months Days If less than one day
76 9 15 -- hr. -- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business - - - -

12. Name Benjamin Short

13. Birthplace Maryland

14. Maiden Name Elizabeth Guyton

15. Birthplace Maryland

16 (a) Informant Rev. Cornelius M. Cuyler

(b) Address 3210 Windsor Avenue

17 (a) Burial (b) Date thereof 10/20/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director W. W. Mears & Son

(b) Address 895 N. Calvert Street

19 OCT 19 1943

(Date rec'd by registrar)

VS 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County - - - - -

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3210 Windsor Avenue

(If rural give location)

(e) Citizen of foreign country? - - - - - (Yes or No)

If yes, name country - - - - -

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/43 19 10:15 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 14 1943 to Oct 16/43 1943, and that I last saw her alive on Oct 16 1943.

Immediate cause of death

Subacute hemorrhage
and paronychia

Due to

Chronic sclerosis (arteriosclerosis)

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) County (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2224 Garrison

Date signed

Oct 18/43

Duration

2 days

1

1

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09260
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

3 (a) FULL NAME

Baby Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 14, 1943

8. AGE:

Years

Months

Days

If less than one day

2

hr.

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Clarence Edwards Taylor

13. Birthplace

Jackson Louisiana

14. Maiden Name

Sally Euka Morrison

15. Birthplace

Jackson City, Tenn.

16 (a) Informant

Mother Sally R. Taylor

(b) Address

833 Jack St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 19 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

19 (a)

(Date rec'd by registrar)

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

833 Jack St., Balto.

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 16 1943

at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943 to Oct 16 1943 and that I last saw him alive on Oct 16 1943.

Immediate cause of death

Pneumonia

Due to

Aspiration of Lung

Due to

Aspiration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Naray Friedman

23. Signature

Address 2326 Eutaw St

Date signed

10/16/43

0451

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09261

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3908 N. Charles Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Lawrence J. Byrne

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-09-1857

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Margaret A. Byrne

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Sept. 21, 1884

8. AGE: Years Months Days If less than one day

59

0

29 27

hr.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual Occupation

Barman, joiner

11. Industry or business

FATHER
MOTHER

12. Name

James Byrne

13. Birthplace

Ireland

14. Maiden Name

Mary Roche

15. Birthplace

Ireland

16 (a) Informant Mrs. Margaret A. Byrne

(b) Address 1306 Valley St

17 (a) Burial

(b) Date thereof Oct. 22, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Mary's Cathedral Cemetery

Location

4300 Old Frederick Rd.

18 (a) Funeral director

Charles W. Condit, Son

(b) Address

924 E. Eager St.

OCT 19 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 1306 Valley Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 - 1943, at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Horton J. Williams

M.D.

Date signed 10/22/43

Medical Examiner.

G 09262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09262
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 204 N. Kenwood Ave
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life3 (a) FULL NAME Joseph Hoppe Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or deceased

6 (b) Name of husband or wife Sarah E.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) August 15-1851

8. AGE: Years Months Days If less than one day

9221

hr.

min.

9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual Occupation Retired

11. Industry or business

12. Name John Hoppe13. Birthplace England14. Maiden Name unknown15. Birthplace England16 (a) Informant John Korymanny
(b) Address 204 N. Kenwood Ave17 (a) Burial (b) Date thereof Oct 20-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory BaltimoreLocation Baltimore Md18 (a) Funeral director Friedenreich & Co(b) Address 1200 W. Baltimore StOCT 10 1943 Registrar Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 204 N. Kenwood Ave
(If rural give location)(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16-1943 at 10:57 PM21. I certify that death occurred on the date above stated; that I attended deceased from March 12-1919 to 10-16-1943; and that I last saw him alive on 10-15-1943.

Immediate cause of death

Organic Heart DiseaseDue to same

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Christa RilandAddress 2532 Edmondson M. D. Date signed 10-17-43

Duration

unknown

PHYSICIAN

Underline the cause in which death should be charged statistically.

G 09263

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09263

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Rita Maria Newkirk

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 30, 1943

8. AGE:

Years

Months

Days

If less than one day

17

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Irvin Newkirk

13. Birthplace

Baltimore, Md.

14. Maiden Name

Allura Ashman

15. Birthplace

Baltimore, Md.

16 (a) Informant

Irvin Newkirk

(b) Address

1912 Hendricks Ave.

17 (a) Burial, cremation, or removal

(b) Date thereof

10/17/43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

St. Joseph's Hospital

18 (a) Funeral director

Huntington Williams, M.D.

(b) Address

1501 E. St.

OCT 19 1943

VS 160

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1912 Hendricks Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1943, at 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1943, to Oct. 17 1943.

and that I last saw him alive on Oct. 17 1943.

Immediate cause of death

Bronchopneumonia

Duration

Due to

Due to

Other Conditions

Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

William H. Lusting

Address

St. Joseph's Hosp.

Date signed

10/17/43

G 09264

AB-82827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09264

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **4940 Eastern Ave.**
- (c) Hospital or institution:
Baltimore City Hospitals
2 Mos. 16 Days
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) **19 Yrs.**

3 (a) FULL NAME

Mary Palmer

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or
divorced

Separated

6 (b) Name of husband or wife

James

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. **Nov. 8-1920**8. AGE: Years Months Days If less than one day
22 11 11 hr min9. Birthplace **N.C.**

(Town, county, and state)

10. Usual Occupation **Unable to work**

11. Industry or business

12. Name **William Savage**13. Birthplace **N.C.**14. Maiden Name **Lennie Dixon**15. Birthplace **N.C.**16 (a) Informant **Baltimore City Hospitals**(b) Address **Records**17 (a) **Burial** (b) Date thereof **October 24, 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Mount Zion**
Location **Baltimore County**18 (a) Funeral director **Joseph A. Spivey**(b) Address **409 N. Mount Street**

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

19 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **506 Eisten St.**

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **10-19 1943** at **4:20** M21. I certify that death occurred on the date above stated; that I attended
deceased from **7-24 1943** to **10-19 1943**
and that I last saw **her** alive on **10-19 1943**.

Immediate cause of death

Organized Pneumonia
Due to **Lobar**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature **Donald B. Smith**Address **Baltimore City Hosp** Date signed **10-19-43**

Duration

3 mos

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09265

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 818 S. Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Johanna Mummann

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife John Mummann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 78 Months 8 Days 10 If less than one day hr. min.

9. Birthplace

Germany (Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

FATHER
MOTHER

12. Name Fredrich Melli

13. Birthplace Germany

14. Maiden Name Not known

15. Birthplace Germany

16 (a) Informant John Mummann

(b) Address 818 S. Rose St.

17 (a) Burial (b) Date thereof Oct. 20-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director John A. Miller

4 Jefferson St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltr.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 S. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1943 to Oct. 16 1943, and that I last saw him alive on Oct. 16 1943.

Immediate cause of death Acute Cor. vascular de ficiency Duration 48 hr.
Due to Chr. Endocarditis
Myocarditis & Chr. Nephritis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury May Temple

23. Signature May Temple

Address 2002 E. Pratt St. Date signed 10/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

309266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309266 Registered No.

1. PLACE OF DEATH: *Baltimore Maryland*
 (a) Baltimore City, Maryland
 (b) Street address *305 W. Hoffman St*
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *11*
 (e) Length of stay in Baltimore (yrs., mos., or days) *40*

2. USUAL RESIDENCE OF DECEASED:
 (a) State *city* (b) County *Baths*
 (c) City or town *city*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *305 W Hoffman St*
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME *Charles Shurtz*
 3 (b) If veteran, name war *World Wars*
 3 (c) Social Security Account No. *219-81-8578*
 4. Sex *Male* 5. Color or race *Caucasian* 6 (a) Single, married, widowed, or divorced *married*
 6 (b) Name of husband or wife *Christine Shurtz*
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 28*
 8. AGE: Years *55* Months *6* Days *19* If less than one day hr. min.

9. Birthplace *Winstons N. J.*
 10. Usual Occupation *Mechanic*
 11. Industry or business

12. Name *Camelia Shurtz*
 13. Birthplace *Winstons N. J.*
 14. Maiden Name *Mary*
 15. Birthplace *Winstons N. J.*

16 (a) Informant *Christine Shurtz*
 (b) Address *305 W. Hoffman St*
 17 (a) *Buried* (b) Date thereof *11-20-43*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Andrew Cemetery*
 Location *Baltimore Md.*
 18 (a) Funeral director *Joseph A. Haddi*
 (b) Address *2101 W. E. Duluth St.*

19 (a) (Date rec'd by registrar) *Washington Williams* Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH *Oct. 17th. 1943. 10:15 A.M.*
 21. I certify that death occurred on the date above stated, that I attended deceased from *Oct. 1st. 1943* to *Oct. 17th. 1943* and that I last saw him alive on *10-15-1943*

Immediate cause of death *Acute Cardiac Dilatation* Duration *Immediate*
 Due to *Myocarditis Endocarditis* *unknown*
 Due to
 Other Conditions
 (Include pregnancy within 3 months of death)
 Date of operation
 Major findings of operation:
 of autopsy:

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at *11*
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury
 23. Signature *Joseph A. Haddi*
 Address *401 E. 25th. St.* Date signed *10/18/43*

OCT 20 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G 09267
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2572 W. Balt. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 2572 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bealis
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Female 5. Color or race W 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Rius Bealis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1986
8. AGE: Years 57 Months Days If less than one day hr. min.

9. Birthplace Luth.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

12. Name
13. Birthplace Luth.
14. Maiden Name
15. Birthplace Luth.

16 (a) Informant Rius Bealis
(b) Address 2572 W. Baltimore St.

17 (a) Burial (b) Date thereof Oct. 20-53
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Ceu.
Location Belair Rd.

18 (a) Funeral director Joseph Kasinski Jr.
(b) Address 602 Wash. Bldg

19 (a) OCT 20 1943 (b) Huntington Williams, M.D.

20. DATE OF DEATH 10/17 1943 at 7 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1943 to 10/17 1943 and that I last saw him alive on 10/17 1943
Immediate cause of death Acute Cardiac Failure
Due to Cancer of Sigmoid & metastases
Due to Chronic Myocarditis
Other Conditions Calcium
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph S. Kasinski M. D.
Address 602 Washington Bldg Date signed 10/14/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09268
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Alice Paynter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife WARREN PAYNTER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT. 9 - 1858

8. AGE: Years 85 Months — Days 8 hr. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

12. Name ARCHIBALD PAYNTER

13. Birthplace IRELAND

14. Maiden Name VANE L. RITCHIE

15. Birthplace BALTO. MD

16 (a) Informant MR. EUGENE PAYNTER

(b) Address 1501 LOCKWOOD ROAD

17 (a) Burial (b) Date thereof 10/20/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory LUDEN PARK
Location

18 (a) Funeral director J. S. Evans, Inc.

(b) Address 118 N. Mt. Royal Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1501 Lockwood Road
(If rural give location)(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1943, 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1943 to 10-17 1943, and that I last saw her alive on 10-17 1943

Immediate cause of death

Intracranial Hemorrhage

Duration 3 hrs.

Due to Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry B. Klyanowicz

Address St. Joseph's Hospital Date signed 10-21-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 20 1943 Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09269
1310 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 417 N. Glover St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

MARGARET WOLF

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife John Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1868

8. AGE: Years

75

Months

8

Days

17

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER

12. Name John Schoenhals

13. Birthplace Germany

MOTHER

14. Maiden Name Don't know

15. Birthplace Germany

16 (a) Informant A.F. Walker

(b) Address 417 N. Glover St.,

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct 20, 1943

(month) (day) (year)

(c) Cemetery or crematory Trinity

Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Orleans St.,

19 (a)

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 417 N. Glover St.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1943 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1943 to Oct 17 1943, and that I last saw her alive on Oct 17 1943.

Immediate cause of death

Uremia - Sh. nephritis.

Cardio-vascular renal disease

Due to arterio-sclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Louis M. Krueger

Address 722 N. Howard

Date signed

M. D.

Oct 1943.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09270
Registered No. 70

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County **QUEEN ANNE'S CO.**

(c) City or town **Queenstown**
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Georges CANAVARRO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Helen

6 (c) If alive, give age **57** years

7. Birth date of deceased (mo., day, yr.) **1-9-85**

8. AGE: Years Months Days If less than one day

58 9 9 hr. min.

9. Birthplace

HAWAII
(Town, county, and state)

10. Usual Occupation

FARMER

11. Industry or business

FATHER
MOTHER

12. Name **A de S. CANAVARRO**

13. Birthplace **Portugal**

14. Maiden Name **MIRANDA HIDALGO**

15. Birthplace **Texas**

16 (a) Informant

Records

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **BURIAL** (b) Date thereof **OCT 21 1943**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **OLD WYE**
Location **WYE MILLS, MD**

18 (a) Funeral director **BARTON BROS**

CENTREVILLE MD

19 **OCT 20 1943** (Date rec'd by registrar) **Huntington Williams, M.D.** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT 18 1943** **8:15 P M**

21. I certify that death occurred on the date above stated; that I attended deceased from **July 26 1943** to **OCT 18 1943**, and that I last saw him alive on **OCT 18 1943**.

Immediate cause of death

Coronary Occlusion
Due to **Arterio-Sclerotic Heart Disease**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence **at M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **J.R. Freeman Jr.** M.D.
Address **J. Hopkins Hospital** Date signed **10/19/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *N. Broadway*
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (year, month, or days) *10*
(e) Length of stay in Baltimore (year, month, or days) *54*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County *Baltimore*
(c) City or town *Baltimore Catonsville*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *104 N. Rolling Road*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *M. George Wimmer*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *M*

6 (b) Name of husband or wife *Katherine Wimmer*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *August 22, 1889*
8. AGE: Years *54* Months *1* Days *27* If less than one day hr. min.

9. Birthplace *Ba No, Md.*
(Town, county, and state)

10. Usual Occupation *Surveyor*
11. Industry or business

12. Name *Wm. G. Wimmer*
13. Birthplace *Maryland*
14. Maiden Name *Mary Catherine Hull*
15. Birthplace *Maryland*

16 (a) Informant *Hospital Records*
(b) Address

17 (a) *Burial* (b) Date thereof *Oct 22/43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Green Ridge*
Location *Catonsville, Md.*

18 (a) Funeral director *John O. Mitchell*
(b) Address *1900 Eastland Place*

Oct 20 1943 (b) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 19 1943* at *4:15 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/6* 1943, to *10/19* 1943, and that I last saw him alive on *10/19* 1943.

Immediate cause of death
Myocardial Infarction

Due to
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy *Same*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *W. G. Wimmer*

Address *Church Home and Hospital* Date signed *10/20/43*

Duration
2 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09272

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2024 Fountain St

(c) Hospital or institution:

Home.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2024 Fountain St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Albin Zuromski (Albin Zuromski)

3 (b) If veteran, name war

3 (c) Social Security Account

No. 705-09-6225

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1943, at 3:10 M

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

WIDOWED

6 (b) Name of ~~husband~~ wife ANNA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE: Years

Months

Days

If less than one day

75

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

B. & O. R. R. CO.

FATHER
MOTHER

12. Name

unknown

13. Birthplace

Poland

14. Maiden Name

unknown

15. Birthplace

Poland

16 (a) Informant

Andrew Zuromski

(b) Address

2024 FOUNTAIN ST

17 (a)

Burial

(b) Date thereof

10-23-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

St. Stanislaus

Location

Baltimore md

18 (a) Funeral director

George A. Wieber

(b) Address

1. Annapolis St

(c) City

Huntington Williams, Md.

(Date rec'd by registrar)

Registrar

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Johnson M.D.

Medical Examiner.

Date signed Oct. 19, 1943

09273 442436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09273
Registered No.MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 737 N. Gay St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mary E. Pennington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Sep.

6 (b) Name of husband or wife

Jeremiah Pennington

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

10/4/88

8. AGE: Years

Months

Days

If less than one day

55

13

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Choral Women

11. Industry or business

12. Name

Charles Cole

13. Birthplace

Md.

14. Maiden Name

Lourena Hopkins

15. Birthplace

Md.

16 (a) Informant

Record

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(b) Date thereof

Oct. 21, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary Cem.

Location

A. A. County, Md.

18 (a) Funeral director

Mrs. Robert A. Elliott & Son

(b) Address

129 N. Caroline St.

19 (a) Date of death

OCT 20 1943

(b) Name of registrar

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/17/43

1943, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1943 to Oct 17 1943, and that I last saw her alive on Oct 17 1943.

Immediate cause of death

secondary carcinoma of liver

Duration

2 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 13, 1943

Major findings of operation:

Inoperable carcinoma of liver & S. B.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

George Bunch Jr.

M. D.

Address

Johns Hopkins Hosp.

Date signed

10-18-43

G 09274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09274
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 422 Greene Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Greene Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rosalie Ceppi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

FemaleWhiteWidowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 - 1891

8. AGE:

Years

Months

Days

If less than one day

5255

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name JOSEPH GEPPi

13. Birthplace

Italy

14. Maiden Name

Sarah Meeta

15. Birthplace

Italy16 (a) Informant S. Ceppi(b) Address 422 N. Greene St.17 (a) Burial(b) Date thereof 10/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.Location Old Frederick Rd.18 (a) Funeral director Joseph Forace Inc.(b) Address 2013 Greenmount Ave19 (a) 20 1943Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1943 at 130 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 10/14th 1943, to 10/17th 1943, and that I last saw her alive on 10/17th 1943

Immediate cause of death

Cerebral Hemorrhage

Due to

Cerebral arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. J. TinkerAddress 100 N. Holladay Date signed 10/20/43

Duration

5 days

Due to

2

Due to

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **99275**

 1. PLACE OF DEATH:
(a) Baltimore City, Maryland

 (b) Street address **2515 Maryland Ave**
(c) Hospital or institution:

 (d) Length of stay in hospital or inst. (yrs., mos., or days) **12**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

 3 (a) FULL NAME **Edward C. Hartman**

 3 (b) If veteran, name war **W** 3 (c) Social Security Account No. **none**

 4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Widowed**

 6 (b) Name of husband or wife **Rita C. Hartman** 6 (c) If alive, give age years

 7. Birth date of deceased (mo., day, yr.) **Sept 4 - 1891**

 8. AGE: Years **52** Months **1** Days **15** hr. min.

 9. Birthplace **Balto. Md.** (Town, county, and state)

 10. Usual Occupation **Auditor**

 11. Industry or business **U.S. Maritime Service**

 12. Name **J. Edward Hartman**

 13. Birthplace **Unknown**

 14. Maiden Name **Louise K. Reelin**

 15. Birthplace **Balto. Md.**

 16 (a) Informant **Francis E. Hartman**

 (b) Address **2515 Md. Ave**

 17 (a) **Burial** (b) Date thereof **10/22/43** (month) (day) (year)

 (c) Cemetery or crematory **Lorraine** Location **Balto. Co. Md.**

 18 (a) Funeral director **William Bok Inc**

 (b) Address **1217 St. Paul St.**

2. USUAL RESIDENCE OF DECEASED:

 (a) State **Md** (b) County

 (c) City or town **Balto** (If outside city or town limits, write RURAL, and give town)

 (d) Street No. **2515 Maryland Ave** (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

 20. DATE OF DEATH **Oct 19 - 1943**

 21. I certify that death occurred on the date above stated; that I attended deceased from **10-14 1943** to **10-19 1943**, and that I last saw him alive on **10-18 1943**.

 Immediate cause of death **Coronary thrombosis**

 Due to **hypertension and arteriosclerosis**

Due to

Other Conditions

(Include pregnancy within 3 months of death) Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

 23. Signature **George H. Cross** Address **28 W 25th St.** Date signed **10-19-43**

 Duration **Just prior**

 2 Known **1 yr.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

09276

09276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09276
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

Street address *1915 W. Fairmount Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Balto*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1915 W. Fairmount Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George W. Gernhart

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. *none*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife *Margaret M. Gernhart*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov 29 - 1883*

8. AGE: Years Months Days If less than one day

59 49 19 hr. min.

9. Birthplace *Balto. Md.*

(Town, county, and state)

10. Usual Occupation *Salesman*

11. Industry or business *Meadow Ridge Memorial Park*

12. Name *George Gernhart*

13. Birthplace *Balto. Md.*

14. Maiden Name *Ida Porter*

15. Birthplace

16 (a) Informant *Margaret M. Gernhart*

(b) Address *1915 W. Fairmount Ave*

17 (a) *Burial* (b) Date thereof *10/22/43*

(Burial, cremation, or other) (month) (day) (year)

(c) Cemetery or crematory *U.S. National*

Location *Balto. Md.*

18 (a) Funeral director *William Cook Inc*

(b) Address *1217 St. Paul St.*

(a) *20 1943* (b) *Huntington Williams, M.D.*

(Official record of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 18 1943 10 48 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 18 1943* to *Oct 18 1943*.

and that I last saw him alive on *Oct 15 1943*.

Immediate cause of death

*Acute cardiac dilatation
Pulmonary tuberculosis*

Due to

Due to

Other Conditions *Rectal fistulas
Tuberculosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury *Alcohol*

23. Signature *A. Calas*

Address *477 Fulton*

Date signed *10/19*

Duration

1 hr.

6 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09277
Registered No.

T.N. 88734

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Charles M. Beaver

3 (b) If veteran, name war

3 (c) Social Security Account
No. NONE

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife

Sara (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 15, 1869

8. AGE: Years Months Days If less than one day

74

8

3

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Iron Molding

11. Industry or business

12. Name James (A) Beaver

13. Birthplace Maryland

14. Maiden Name Sarah Gough Miller

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 10/21/43

(Burial, cremation, or other disposal)

(month) (day) (year)

(c) Cemetery or crematory

Balto.

Location

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 OCT 20 1943

(Date and by Registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1943, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1941, to 10-18 1943, and that I last saw him alive on 10-18 1943.

Immediate cause of death

Heart 8 months of coronary
Due to Syphilitic Aortic
regurgitation

Other Conditions Aneurysm, cerebral

Anterior - Posterior
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Hattme

Address B.C.H. Date signed 10/18/43

Duration
Few
months
1 year
PHYSICIAN
Underline the
cause to which
death should be
charged statisti-
cally.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

278

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

09278

170c

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1718 McKean Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary A. Dietz

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. DATE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband George Dietz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26th 1895

8. AGE: Years Months Days If less than one day

67

9

23

hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

12. Name John Ruppel

13. Birthplace Unknown

14. Maiden Name France

15. Birthplace

16 (a) Informant Miss Louise Dietz

(b) Address 1718 McKean Ave

17 (a) Burial (b) Date thereof 10/23/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Holy Redeemer

Location Balto Md

18 (a) Funeral director William Cook, Inc

(b) Address 1217 S. Paul St

19 (a) OCT 20 1943 (b) Huntington Williams MD

(Date of death) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 1943, at 9 A M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Broncho pneumonia

Due to

Other Conditions Fractured clavicle & ribs

multiple contusions & lacerations

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of

death, fill in the following:

(a) Date of injury 10-16-43 7 P. 15/2

(b) Where did injury occur? Morris & Westcott Sts.

(c) Did injury occur at home, on farm, industrial place, in public

place? Public While at work? No

(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Wallace M.D.

Date signed 10-19-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09279
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1112 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Cody F. Gemmill

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Margaret Gemmill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 - 1874

8. AGE: Years 69 Months 4 Days 5 If less than one day hr. min.

9. Birthplace

Balto. Md.

10. Usual Occupation

Stationary Fireman

11. Industry or business

Balto. Transit Co

FATHER

12. Name Benjamin B. Gemmill

13. Birthplace Balto. Co. Md.

MOTHER

14. Maiden Name Sarah R. Eddie

15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs Margaret Gemmill

(b) Address 1112 Greenmount Ave

17 (a) Burial (b) Date thereof 10/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Market

Location Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 - 1943 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1941 to Oct 18 1943 and that I last saw him alive on Oct 10 1943

Immediate cause of death

Coronary occlusion

Due to

Hypertensive

Due to

Cardiovascular

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature Jack J. Singer M.D.

Address 506 E. North Ave Date signed 10/18/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

101-20-1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. 9280

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 9280

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2140 Walbrook Ave.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

IDA A. PARKS

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or
divorced. married

6 (b) Name of husband or wife. Joshua E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1861

8. AGE: Years 82 Months 7 Days 7 If less than one day
hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name -- Smith

13. Birthplace Germany

14. Maiden Name unknown

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Joshua E. Parks

(b) Address 2140 Walbrook Ave.

17 (a) Burial (b) Date thereof 10/20/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

OCT 20 1943 (a) (b)
(Date received by registrar)Huntington Williams, M.D.
Registrar

V8 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2140 Walbrook Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1943 to Oct 17 1943 and that I last saw him alive on Oct 17 1943

Immediate cause of death

Cardiac asthma

Due to Angina pectoris

Due to Ischemic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Gun

23. Signature

Address 806 N. E. St. Date signed Oct 19 1943 M. D.

Duration
2 days

2 days

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09281

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Greene Sts.*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *7 days*

3 (a) FULL NAME *Mr. Lewis Phillips*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife *Mamie Phillips*

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *1883*

8. AGE:

60 yr.

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace *Fruitland Md*

(Town, county, and state)

10. Usual Occupation *Farmer*

11. Industry or business *Farming*

12. Name

13. Birthplace

14. Maiden Name *Mattie?*

15. Birthplace

16 (a) Informant *W. J.*

(b) Address *Fruitland Md*

17 (a) *Removal* (b) Date thereof *10-20-43*

(Burial, cremation, or removal)

(c) Cemetery or crematory *Salisbury*

Location *Salisbury, Maryland*

18 (a) Funeral director *Traylor & Company*

(b) Address *Salisbury, Maryland*

19 (a)

Oct 20 1943 Registrar *Huntington Williams, Jr.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*

(b) County *Wicomico*

(c) City or town *Fruitland*

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country? *no* (If rural give location)

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-19-43* 19 at *7 P M*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-13-43* 19 to *10-19-43* 19 and that I last saw him alive on *10-19-43* 19

Immediate cause of death *Increased intra-cranial pressure*

Due to *Brain tumor*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *10-16-43*

Major findings of operations: *Brain tumor*

of autopsy: *Brain tumor*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature *Raymond S. Parry, Jr.*

Address *University of Maryland*

Date signed *10-19-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09282

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 619 S. Linwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 619 S. Linwood Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Katherine Drankiewicz

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Barthomy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 - 1865

8. AGE: Years Months Days If less than one day

77 79 10 21 hr. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

12. Name

13. Birthplace

Poland

14. Maiden Name

Nowak

15. Birthplace

Poland

16 (a) Informant Frank Drankiewicz

(b) Address 619 S. Linwood Ave

17 (a) Burial (b) Date thereof Oct 21 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baito Rd

18 (a) Funeral director William F. Kowalski

(b) Address 1618 Eastern Ave

OCT 20 1943

(c) Registrar

VS 124

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1943 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Oct 16 1943, and that I last saw him alive on Oct 16 1943.

Immediate cause of death

Myocardial Infarction

Due to Chr. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Ryan

Address 801 Keweenaw Date signed Oct 23

Duration 10/12/43

5/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09283

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2218 N. Howard St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

3 (a) FULL NAME

Alice R. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Female

5. Color or race

col

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 2/1898

8. AGE: Years Months Days

45 9 25

If less than one day

hr. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

12. Name William Burrell

13. Birthplace

Va

14. Maiden Name

Pattsey Brooks

15. Birthplace

Va

16 (a) Informant

Annie Thomas

(b) Address

2218 N. Howard St

17 (a) Burial

(b) Date thereof

10 30 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

A. A. Co

18 (a) Funeral director

Paymer Sanders

(b) Address

412 E. Preston St

19 (a)

(b)

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2218 N. Howard St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-16-43

19

at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1943, to 10-16-1943, and that I last saw him alive on 10-16-1943.

Immediate cause of death

Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. J. Davis

Address

312 E 23rd St

Date signed

M. D.

10-15-43

OCT 20 1943

G 09284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09284

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6 S. Carey St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Jennie Fonte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Femalewhitemarried6 (b) Name of husband or wife Samuel6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

7/13/1887

8. AGE: Years Months Days

If less than one day

5636

hr.

min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER12. Name George Young13. Birthplace Baltimore M.D.14. Maiden Name Emma Vinyard15. Birthplace Baltimore M.D.16 (a) Informant Samuel Fonte(b) Address 6 S. Carey St.17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof Oct. 22-1943
(month) (day) (year)(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd.18 (a) Funeral director Joseph Ferace Inc.(b) Address 2012 Greenmount Ave

OCT 20 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 6 S. Carey St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1943 at 4 M21. I certify that death occurred on the date above stated, that I attended deceased from Jan 15 19 to Oct 19 1943, and that I last saw him alive on Oct 18 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Harry GlassmanAddress 253 N. Federal St.Date signed Oct 20 1943

M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Martin J. Frederick
4835 Kewarick Road
Balt. Md.

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

09285
 Registered No.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address *Calvert + Haratoga*
 (c) Hospital or institution: *Mercy Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:
 (a) State *md* (b) County
 (c) City or town *Balt*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *4835 Kewarick Road*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME *Martin J. Frederick*
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex *M*
 5. Color or race *W*
 6 (a) Single, married, widowed, or divorced. *W*

6 (b) Name of husband or wife *Rosa Buchner*
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *7/17/1856*

8. AGE: Years *87* Months *3* Days *3* If less than one day hr. min.

9. Birthplace *Baltimore Md.*
 (Town, county, and state)

10. Usual Occupation *Retired*

11. Industry or business

12. Name *Michael Frederick*
 13. Birthplace *Germany*

14. Maiden Name *Rosa Buchner*
 15. Birthplace *Balt. Md.*

16 (a) Informant *Mrs. Fred Schanberger*
 (b) Address *1810 H. Paul St.*

17 (a) (Burial, cremation, or removal) *B.* (b) Date thereof *10-23-43*
 (month) (day) (year)

(c) Cemetery or crematory *Holy Redeem*
 Location *Belair Rd.*

18 (a) Funeral director *Jess. L. G. Carey*
 (b) Address *130 E. Fort Ave.*

19 (a) *OCT 20* (b) *Huntington Williams*

For *J. R. L. Graham - by Howard J. Lusk, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 20* 19*43*, at *2:30 A.M.*

21. I certify that death occurred on the date above stated, that I attended deceased from *Oct 19* 19*43* to *Oct 20* 19*43*, and that I last saw him alive on *Oct 20* 19*43*.

Immediate cause of death *Cardio-Resp. Failure*

Due to *Pulmonary Emphysema*

Due to *Cerebral Hemorrhage*

Other Conditions *Fracture Left Humeral*
 (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide *Accident*

(b) Date of occurrence *October 20* 19*43* at *5:30 P.M.*

(c) Where did injury occur? *4835 Kewarick Rd.*
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *At home* While at work? *No*
 (Specify type of place)

(e) Means of injury *Fall to floor*

23. Signature *Marion K. Adelschmidt, M.D.*

Date signed *10/20/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09286

Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland *Gaddis Nursing Home*
 (b) Street address *Clowdsdale Rd Balt. Md*
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *6 1/2 yrs*
 (e) Length of stay in Baltimore (yrs., mos., or days) *6 1/2 yrs*

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Penn.* (b) County *Allegheny Co*
 (c) City or town *Pittsburgh Pa.*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country

3 (a) FULL NAME *Carrie Wolf*
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex *Female* **5. Color or race** *White* **6 (a) Single, married, widowed, or divorced** *widowed*
 6 (b) Name of husband or wife *Max Wolf*
 6 (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) *April 13 1868*
 8. AGE: Years *75* Months *6* Days *7* If less than one day hr. min.
 9. Birthplace *Pittsburgh Pa*
 (Town, county, and state)
 10. Usual Occupation *Housewife*
 11. Industry or business

12. Name *Charles Falk*
13. Birthplace *Germany*
14. Maiden Name *Sarah Sander*
15. Birthplace *Germany*

16 (a) Informant *Jessie Falk Forst*
(b) Address *Schenley Apts Pittsburgh Pa*

17 (a) Removal (b) Date thereof *10-20-43*
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory *Pittsburgh Pa*
 Location

18 (a) Funeral director *Jack Lewis*
(b) Address *11439 E. 1st St*

19 (a) *OCT 20 1943* *Huntington Williams*
 (Date and day registered) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH *OCT 20 1943* at *6:40* M
21. I certify that death occurred on the date above stated; that I attended deceased from *May 18 1937* to *OCT 20 1943*
 and that I last saw him alive on *1:30 AM 1943*
 Immediate cause of death *Respiratory and cardiac failure*
 Due to *cause unknown*
 Due to *neurological condition*
9 left ear and face
 Other Conditions
 (Include pregnancy within 3 months of death)
 Date of operation *None*
 Major findings of operation:
 of autopsy:
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
 (e) Means of injury
23. Signature *Leslie B. Holman*
 Address *1023 N. Calvert St* Date signed *OCT 20 1943*
 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09287

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/19

1943. at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1943. to 10/19 1943. and that I last saw him alive on 10/19 1943.

Immediate cause of death: Coronary Artery Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (not done yet)

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

10/19/43

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G 39288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2628 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Smallwood St.
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE SHAPRO
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Simon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1862
8. AGE: Years 81 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

12. Name Hyman Smellow
13. Birthplace Russia
14. Maiden Name Sarah
15. Birthplace Russia
16 (a) Informant Jas. Shapro
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-43 (month) (day) (year)
(c) Cemetery or place of interment Rosevale
Location Phila. Rd + Hamilton Ave
18 (a) Funeral director Jas. Shapro
(b) Address 1439 E. Balto St
19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

20. DATE OF DEATH 10-19-43 19 11 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to 10-19-43 and that I last saw him alive on Oct 12 1943.
Immediate cause of death
Due to Hypertensive Cardio-Vascular Disease
Old Cerebral Hemorrhage
Due to Cerebral Hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. A. Venslock
Address 46030 K Moore Date signed 10/19/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

Duration
Several
16 mos
10 mos

10/20/43

G 09289

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09289
Registered No.MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: *Meigs Hospital*

(d) Length of stay in hospital or inst. (yrs., mos., or days) *36 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *one*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Prince George's*

(c) City or town *Laurel, Md.*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *-----*
(If rural give location)

(e) Citizen of foreign country? *-----* (Yes or No)
If yes, name country *-----*

3 (a) FULL NAME *Father J. Myer* (Rev. Joseph A. Myer)

3 (b) If veteran, name was *-----* (c) Social Security Account No. *-----*

4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *Single*

6 (b) Name of husband or wife *-----* 6 (c) If alive, give age *-----* years

7. Birth date of deceased (mo., day, yr.) *Sept. 16, 1872*

8. AGE: Years *71* Months *1* Days *3* If less than one day *--- hr. --- min.*

9. Birthplace *Md.* (Town, county, and state)

10. Usual Occupation *Print*

11. Industry or business

12. Name *C. M. Myer*

13. Birthplace *Md.*

14. Maiden Name *Elizabeth Hilberg*

15. Birthplace *Md.*

16 (a) Informant *Father Myer*

(b) Address *Laurel, Md.*

17 (a) *Burial* (b) Date thereof *10/22/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *New Cathedral*
Location *Baltimore, Md.*

18 (a) Funeral director *W. W. Meers & Son*
Oct 20 1943 5 N. Calvert Street

19 (a) *-----* (b) *-----*
(Date rec'd by registrar) Registrar *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/19* 19*43* *6* AM

21. I certify that death occurred on the date above stated, that I attended deceased from *Sept. 12* 19*42*, to *10/19* 19*43*, and that I last saw h/ *alive* on *10/19* 19*43*.

Immediate cause of death *Heart failure*

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *None*

Major findings of operations

of autopsy *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *-----* at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *J. Carl Myer, M.D.*

Address *Meigs Hospital* Date signed *10/19/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09290

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09290
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 532 N. Carrollton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jennie Dutton Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F 5. Color or race C. 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1874

8. AGE: Years 69 Months 8 Days 15 If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Chas. H. Dutton

13. Birthplace Md

14. Maiden Name Caroline Truaty

15. Birthplace Md.

16 (a) Informant Bernadette L. Dutton

(b) Address 532 N. Carrollton Ave

17 (a) Burial (b) Date thereof 10/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. P.K.
Location Arbutus, Md.

18 (a) Funeral director Joseph B. Locke, Jr.

(b) Address 304 N. Central Ave

19 (a) Huntington Williams, M.D. (b) Registrar

OCT 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1943 at 5:09 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Oct 17 1943 and that I last saw him alive on Oct 15 1943.

Immediate cause of death

Coronary Myocarditis
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. F. Howell

Address 601 N. Carrollton Ave Date signed 10/19/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09291

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09291
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 Homewood Ave
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County X
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2013 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country.

3 (a) FULL NAME Edna E. Fitzgerald
3 (b) If veteran, name war - 3 (c) Social Security Account No. -

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife - 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-19-1867

8. AGE: Years 56 Months 3 Days 19 If less than one day hr. 5 30 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business At Home

12. Name Stephen Fitzgerald

13. Birthplace Ireland

14. Maiden Name Elizabeth Rock

15. Birthplace England

16 (a) Informant Mrs. Irene Fitzgerald

(b) Address 2013 Homewood Ave

17 (a) Burial (b) Date thereof 10-27-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic Cemetery
Location

18 (a) Funeral director Mary M. Wiedefeld

(b) Address 201 E. 7th St.

19 (a) Huntington Williams (b) -
(Date rec'd by registrar) Registrar

001 20 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19, 1943 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to 10/18/1943 and that I last saw her alive on Oct 18, 1943.

Immediate cause of death Carcinoma of bladder Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. M. B. Seale

Address 521 Ind. Ave. Bldg. Date signed 10/20/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09292

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *4314 Anntana Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

George Butterhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widower

6 (b) Name of husband or wife *Josephine M.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 20 - 1860

8. AGE:

Years

Months

Days

If less than one day

82

10

29

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Retired Baker

11. Industry or business

12. Name

Peter Butterhoff

13. Birthplace

Germany

14. Maiden Name

Margaret Vetter

15. Birthplace

Germany

16 (a) Informant

Mrs Emma Stock

(b) Address

4314 Anntana Ave

17 (a)

Burial

(b) Date thereof

10-27-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Hayford Road

OCT 20 1943

William Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4314 Anntana Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 19 1943* at *5:00* M

21. I certify that death occurred on the date above stated; that I attended deceased from *June 1943* to *Oct. 1943*, and that I last saw him alive on *Oct. 1 1943*.

Immediate cause of death

Heart Block.

Due to

arteriosclerotic cardiac

Due to

vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Harold A. Grott

Address *8100 Hayford*

Date signed *10/19/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Dr. Kinney 2700 Harford Road
G 09293
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2706 Alameda Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Elle J. Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife John W. Patterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1956

8. AGE: Years Months Days If less than one day
87 - 10 hr. min.

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name John Varner

13. Birthplace Berma

14. Maiden Name ? Arnold

15. Birthplace Berma

16 (a) Informant Mrs J. L. Bennington

(b) Address 2706 Alameda Ave

17 (a) Burial (b) Date thereof Oct 21-43 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bethel

Location Harford Co. Md

18 (a) Funeral director Leonard J. Ruck

(b) Address 5-305 Harford Road

OCT 20 1943 (b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2706 Alameda Blvd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1943 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1943 to Oct 17 1943 and that I last saw her alive on Oct 17 1943

Immediate cause of death

Cerebral hemorrhage 1 hr.
Due to Crohn's

Due to Hypertensive
Cardio-Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? at M

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Fritz J. Kinney

Address 2700 Harford Road Date signed Oct 18 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09294
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *120 W. Ostend Street*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *120 W. Ostend St*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Bernard J. Mattare Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife *Catherine*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 12, 1874

8. AGE:

Years

Months

Days

If less than one day

69

4

6

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Retired Cabinet Maker

11. Industry or business

12. Name *John Mattare*

13. Birthplace *Baltimore*

14. Maiden Name *Agnes Doyle*

15. Birthplace *Ireland*

16 (a) Informant *Bernard J. Mattare Jr*

(b) Address *107 Bloomsbury Ave*

17 (a) *Burial* (b) Date thereof *10-20-43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer*

Location

18 (a) Funeral director *Leonard J. Ruck*

(b) Address *5305 Bayfield Rd*

19 (a) *OCT 20 1943* (b) Registrar *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 18 1943* at *M*

21. I certify that death occurred on the date above stated, that I attended deceased from *Oct 16 1943* to *Oct 17 1943*

and that I last saw him alive on *Oct 15 1943*

Immediate cause of death

Coronary occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

(e) Means of injury *Isaac Muller*

(f) Signature *Isaac Muller*

Address *120 W. Ostend St*

Date signed *10/20/43*

G 09295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09295

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of face

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof (month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/18/19 at 99. M

21. I certify that death occurred on the date above stated; that I attended deceased from 001-1940, to 001-18-19-43 and that I last saw him alive on May 19-19-43.

Immediate cause of death

Cerebral hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions An Arteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 222 W. Monument

Date signed 10/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OVER

Howard J. Mallick, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09296
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *N. Broadway*
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) *11*
(e) Length of stay in Baltimore (yrs., mos., or days) *56*

2. USUAL RESIDENCE OF DECEASED:

- (a) *MD* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *4742 Green Hill Avenue*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rev. Carol E. Harding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
M

5. Color or race
W

6 (a) Single, married, widowed, or divorced.
M

6 (b) Name of husband or wife *William Harding*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug 23, 1860*

8. AGE: Years Months Days If less than one day
80 1 25 hr. min.

9. Birthplace *Maine*
(Town, county, and state)

10. Usual Occupation *Minister*

11. Industry or business

12. Name *Henry Harding*

13. Birthplace *Maine*

14. Maiden Name *Elizabeth O'Brien*

15. Birthplace *Maine*

16 (a) Informant *Nos. Civil Records*
(b) Address

17 (a) *Burial* (b) Date there *Oct. 22-43*
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory *St. Johns. Presbyterian*
Location *Belona, D.C.*

18 (a) Funeral director *John A. Wilson*
(b) Address *4401 Greenmount Ave*

19 (a) *John A. Wilson, M.D.* Registrar
(b) Address *4401 Greenmount Ave*

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 18 1943* at *12:30 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/8* 1942, to *10/18* 1943, and that I last saw him alive on *10/18* 1943.

Immediate cause of death

A. adenocarcinoma of Rectum

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature *S. J. ...*

Address *Church Home & Hospital* Date signed *10/19/43*

Duration
7 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

09297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09297
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2611 E. Fayette street

(c) Hospital or institution: -----

(d) Length of stay in hospital or inst. (yrs., mos., or days) -- 6

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2611 E. Fayette street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JENNIE AQUINO

3 (b) If veteran, name war -----

3 (c) Social Security Account No. No

4. Sex
Female5. Color or race
white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dominic Aquino

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1882

8. AGE: Years 61 Months 9 Days -- If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

12. Name Joseph Serio

13. Birthplace Italy

14. Maiden Name Mary Merlo

15. Birthplace Italy

16 (a) Informant Mr. Dominic Aquino

(b) Address 2611 E. Fayette street

17 (a) Burial (b) Date thereof 10/21/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

18 (a) Funeral director Chas. J. Evans & Son, Inc.

(b) Address 118 N. Mt. Royal Ave.

19 (a) 10-20-43

(b) rec'd by registrar Huntington Williams, M.D.

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1943 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1942 to 10/16 1943, and that I last saw him alive on 19

Immediate cause of death

Pulmonary Embolism

Due to Carcinoma of the Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. J. Jankin

Address 100 N. Milwaukee Date signed 10/20/43

Duration

45 yr.

18 m.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

9298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09298
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1712 W Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 W Lexington St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie Davis

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex 5. Color or race 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1943, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1943, to Oct 17, 1943, and that I last saw him alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09299

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4330 Berger Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

3 (a) FULL NAME

Agnes Leitschuh

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Widowed

6 (b) Name of husband or wife Daniel Leitschuh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th, 1901

8. AGE: Years 62 Months 5 Days 13 If less than one day min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Michael Heinle

13. Birthplace Germany

14. Maiden Name Elizabeth Decker

15. Birthplace Baltimore Md.

16 (a) Informant Mr. Joseph F. Leitschuh (Son)

(b) Address 4330 Berger Avenue

17 (a) Burial (b) Date thereof Oct. 21, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1728 Harford Ave.

OCT 20 1943

VE 3

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4330 Berger Ave.

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 19 43 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13, 1943, to Oct. 19, 1943, and that I last saw him alive on Oct. 15, 1943.

Immediate cause of death Chronic cholecystitis
choleangitis - Acute - Antecedent -

Duration

Due to Cholelithiasis -
common duct calculus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature J. Brooks, M.D.

Address 5217 Harford Road Date signed 10/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09300
Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address: <i>Redwood + green Sts.</i> (c) Hospital or institution: <i>University Hospital</i> (d) Length of stay in hospital or inst. (yrs., mos., or days): <i>15 days</i> (e) Length of stay in Baltimore (yrs., mos., or days): <i>15 days</i>				2. USUAL RESIDENCE OF DECEASED: (a) State: <i>MD</i> (b) County: <i>Washington</i> (c) City or town: <i>Nagerstown</i> (If outside city or town limits, write RURAL and give town) (d) Street No.: <i>240 Fairground Ave</i> (If rural give location) (e) Citizen of foreign country? <i>no</i> (Yes or No) If yes, name country:			
3 (a) FULL NAME <i>Miss Agnes P. Bonney.</i>							
3 (b) If veteran, name war				3 (c) Social Security Account No. <i>215-18-2777</i>			
4. Sex <i>female</i>		5. Color or race <i>white</i>		6 (a) Single, married, widowed, or divorced. <i>single</i>			
6 (b) Name of husband or wife							
6 (c) If alive, give age years							
7. Birth date of deceased (mo., day, yr.) <i>April 14, 1890</i>							
8. AGE: Years <i>53 yrs.</i> Months <i>6</i> Days <i>5</i>		If less than one day hr. min.					
9. Birthplace <i>Romney, W. Va.</i> (Town, county, and state)							
10. Usual Occupation <i>Bank clerk</i>							
11. Industry or business <i>Banking</i>							
12. Name <i>Edmund Bonney</i>							
13. Birthplace <i>Romney, W. Va.</i>							
14. Maiden Name <i>Elizabeth</i>							
15. Birthplace <i>Romney, W. Va.</i>							
16 (a) Informant <i>Sister</i>							
(b) Address <i>Same as above</i>							
17 (a) Burial (b) Date thereof <i>10/23/43</i> (Burial, cremation, or removal) (month) (day) (year)							
(c) Cemetery or crematory <i>Rose Hill</i> Location <i>Nagerstown Md</i>							
18 (a) Funeral director <i>Andrew H. Hoffman</i>							
(b) Address <i>Nagerstown Md</i>							
19 (a) 20 1943 (b) <i>Huntington Williams, Md</i> Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <i>10-19-43</i> 19 <i>9:10 A</i> M							
21. I certify that death occurred on the date above stated; that I attended deceased from <i>10-6-43</i> 19 <i>to 10-19-43</i> , and that I last saw her alive on <i>10-19-43</i>							
Immediate cause of death <i>Brain tumor - malignant</i>							
Due to							
Due to							
Other Conditions							
(Include pregnancy within 3 months of death) Date of operation <i>10-15-43</i>							
Major findings of operations: <i>Brain tumor malignant</i>							
of autopsy: <i>same</i>							
22. If death was due to external causes, fill in the following:							
(a) Accident, suicide, or homicide							
(b) Date of occurrence at M							
(c) Where did injury occur? (City or town) (County) (State)							
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)							
(e) Means of injury							
23. Signature <i>Raymond E. King</i>							
Address <i>University Hospital</i> Date signed <i>10/22/43</i>							

G 09301
442733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09301
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1618 DELANO COURT.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

PHILLIP REDD.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 213-076435

4. Sex

MALE

5. Color or race

BLACK

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife PEARL

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 9-27-06

8. AGE: Years 37 Months - Days 22 If less than one day
hr. min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

12. Name JOSEPH REDD

13. Birthplace

Va.

14. Maiden Name

Nancy Henderson

15. Birthplace

Va.

16 (a) Informant Records.

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Oct. 23/1943
(month) (day) (year)

(c) Cemetery or crematory

Location Harmville, Va.

18 (a) Funeral director

Eloy O. Wilson

(b) Address

1000 Brently Ave

19 (a) OCT 21 1943
(Date of registration)

Huntington Williams, M.D.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19. 1943, at 8:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12. 1943, to Oct. 19 1943, and that I last saw him alive on Oct. 19 1943.

Immediate cause of death

Uremia

Due to

Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

John R. Birmingham
J.H.H.
M.D.
Date signed 10-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09302

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09302

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Samuel Simmonds

Samuel Simmonds

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Varia Simmonds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

About 1875

8. AGE:

Years

Months

Days

If less than one day

68

--

--

--

min.

9. Birthplace

England

(Town, county, and state)

10. Usual Occupation

Horticulturist

11. Industry or business

Towson Nurseries

12. Name

Unknown

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant

Maurice Jaillette

(b) Address 1314 Conn. Ave., Wash. D.C.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/21/43

(month) (day) (year)

(c) Cemetery or crematory Prospect Hill Cem.

Location Towson, Maryland

18 (a) Funeral director

John Burns' Sons

(b) Address Towson, Maryland

19 (a)

(b) Date filed by registrar

OCT 21 1943

Huntington Williams, Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Towson

(If outside city or town limits, write RURAL and give town)

(d) Street No. Burke Avenue

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1943 at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1943, to 10/19 1943, and that I last saw him alive on 10/19 1943.

Immediate cause of death

Peripneumonic pulmonary collapse

Due to

lobar pneumonia with septicaemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature

James W. Byrnes

M. D.

Address Univ. Hospital

Date signed 10/19/43

G 09303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09303

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *4416 Roland Ave*

(c) Hospital or institution:

Home(d) Length of stay in hospital or inst. (yrs., mos., or days) *57*(e) Length of stay in Baltimore (yrs., mos., or days) *25 yrs.*

3 (a) FULL NAME

Jane Dean Hammond Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife *Jesse C. Boyd*6 (c) If alive, give age *78* years7. Birth date of deceased (mo., day, yr.) *Feb. 4-1868*

8. AGE: Years Months Days

If less than one day

*75 8 16*9. Birthplace *Lebanon, Penna.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *10-4-43*

(c) Cemetery or crematory

*St. Thomas'*Location *Harrison Road, Md.*18 (a) Funeral director *STEWART & MOWEN COMPANY*(b) Address *(W. F. WOODEN SUC.) 108 W. NORTH AVENUE*19 (a) *OCT 21 1943*

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *4416 Roland Ave.*
(If outside city or town limits, write RURAL and give town)(d) Street No. *Balto. City*(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *OCT 19 1943* at *4:15 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Jan 15 1940* to *OCT 19 1943*, and that I last saw him alive on *OCT 19 1943*

Immediate cause of death

*Cerebral arteriosclerosis*Due to *senile factors*Due to *degeneration of arteries*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature *Wilton C. Hill*Address *4416 Roland*Date signed *10/21/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FOR BINDING

09304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09304

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Harbinger Sts.*

(c) Hospital or institution:

Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) *49 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *50 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balti.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *611 St. Paul St*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Cyril Hansell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 2, 1890*

8. AGE: Years Months Days

53

4

17

hr.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

House of Correction

12. Name

Robert B. Hansell

13. Birthplace

England

14. Maiden Name

Emilie Ross

15. Birthplace

England

16 (a) Informant

Cyril Hansell

(b) Address

611 St. Paul St.

17 (a) *Burial*

(b) Date thereof *10-23-43*

(Burial, cremation, or removal)

(c) Cemetery or crematory

Woodlawn

Location

Woodlawn Md

18 (a) Funeral director

STEWART & MOWEN COMPANY

(b) Address

(W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a)

(b) *OCT 21 1943*

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 19, 1943* at *2:15 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 6, 1943*, to *Oct 18, 1943*, and that I last saw him alive on *Oct 18, 1943*.

Immediate cause of death

Cardiac Failure

Due to

Sub-acute Bact. Endocarditis

Due to

Septicemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Robert B. Tunney

Address

Mercy Hosp

Date signed *10/19/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09305
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *None*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *Thro.*

(e) Length of stay in Baltimore (yrs., mos., or days) *87 yrs.*

3 (a) FULL NAME

Dr. David Culbreth (Marvel Reynolds)

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *None*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Helen T. Culbreth*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec-4-1855*

8. AGE: Years Months Days If less than one day
87 10 15 hr. min.

9. Birthplace *Kent Co., Delaware*
(City, county, and state)

10. Usual Occupation *Prof of Pharmacy*

11. Industry or business *Unemployment*

12. Name *Robert B. Culbreth*

13. Birthplace *Delaware*

14. Maiden Name *Sarah Gilder Reynolds*

15. Birthplace *Kent Co., Delaware*

16 (a) Informant *Mrs. Helen T. Culbreth (wife)*

(b) Address *11 E. Chase St., City*

17 (a) *Burial* (b) Date thereof *Oct 22/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Greenmount*

Location *Baltimore City*

18 (a) Funeral director *Stewart & Mowen Co*

(b) Address *108-W North Avenue*

19 (a) *OCT 21 1943*
(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) *MD.* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)

(d) Street No. *11 E. Chase St.*

(e) Citizen of foreign country? *No* (If rural give location) (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 19 1943* at *11:00 P.M.*

21. I certify that death occurred on the date above stated that I attended deceased from *Oct. 19 (1943) 4:30* to *Oct. 19 1943*, and that I last saw him alive on *Oct. 19 1943*.

Immediate cause of death

Cardiac Decompensation

Due to *Semility*

Due to

Other Conditions *Fecal & urinary incontinence*
(Include pregnancy within 3 months of death)

Date of operation *None*

Major findings of operations

of autopsy *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature *R. A. Reynolds, Jr.*

Address *University Hosp* Date signed *10/24/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09306
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
hr. min.9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 19 1943 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1943 to 10-19 1943 and that I last saw him alive on 10/18 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

2 days

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 21 1943

VS 1

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09307
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6738 E. Pratt St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

SYBILLA CAROLINE MEYER

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 215-10-4334

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 20, 1885

8. AGE: Years Months Days

57

11

28

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Forelady

11. Industry or business International Bedding Co.

12. Name Henry Meyer

13. Birthplace Baltimore, Maryland

14. Maiden Name Margaret Endress

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Douglas Gilpin

(b) Address 6738 E. Pratt St.

17 (a) Burial (b) Date thereof 10/21/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 19439 E. North Ave.

OCT 21 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6738 E. Pratt St.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1943 to 10/18 1943, and that I last saw him alive on 10/18 1943.

Immediate cause of death

malignant endocarditis

Due to chronic endocarditis

Due to rheumatic arthritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

L. E. Schiller

Address 4474 Kenwood Ave.

Date signed 10/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09308

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2934 McElderry St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Mr. James Edward Waddey Sr.

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 212-14-3859

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Ida Virginia

Eichelberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1883

8. AGE:

Years

77

Months

3

Days

6

If less than one day

hr.

min.

9. Birthplace Fairfax, Va.

(Town, county, and state)

10. Usual Occupation Shop Clerk

11. Industry or business The Slayman Co.

12. Name James Edward Waddey

13. Birthplace Virginia

14. Maiden Name Mary

15. Birthplace Virginia

16 (a) Informant Ida Virginia Waddey

(b) Address 2934 McElderry St.

17 (a) Burial

(b) Date thereof 10/22/43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1642 E. North Ave.

19

OCT 21 1943

(Date rec'd by registrar)

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1943, 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1943, to Oct. 19, 1943, and that I last saw him alive on Oct. 19, 1943.

Immediate cause of death

Broncho pneumonia

Duration

Due to

Due to

Other Conditions

Arteriosclerosis, generalized.

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Lusting M.D.

Address St. Joseph's Hosp. Date signed 10-19-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09309
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4301 Arizona Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME

George Trabert

3 (b) If veteran, name war

Ad

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, year)

Aug 5 - 1864

8. AGE: Years

79

Months

2

Days

14

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Tailor

12. Name

John Trabert

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Elizabeth Batrand

(b) Address

4301 Arizona Ave

17 (a) Burial

(Burial, cremation, or other)

(b) Date thereof

10/22/43

(c) Cemetery or crematory

Holy Redeemer

Location

Balto Md

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

19 (a) Date of death

Oct 19 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4301 Arizona Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 19 1943 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1943 to Oct 19 1943 and that I last saw him alive on Oct 19 1943.

Immediate cause of death

arterio sclerosis

Duration

15 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J J Martin

M. D.

Address

7101 Bay Road

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09310
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address W B G H.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 836 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CHALMER RAY DUNCAN JR.

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex
M

5. Color or race
W

6 (a) Single, married, widowed, or
divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 43

8. AGE: Years Months Days If less than one day
1 333 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Chalmer Ray

13. Birthplace Tenn.

14. Maiden Name Essie Tavis

15. Birthplace Tenn.

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (b) Date thereof 10/21/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Clinton Tenn.

18 (a) Funeral director William J. Ticknor & Sons

(b) Address North & Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams
Registrar

VS 100

Oct 21 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1943 at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1943 to Oct. 21 1943, and that I last saw him alive on Oct 21 1943.

Immediate cause of death

Status lymphaticus.

Due to

Due to

Other Conditions

Infantile eczema.
(Include pregnancy within 6 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Jeffrey Seelen
Address West Baltimore Hospital Date signed Oct 21 43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09311	
CERTIFICATE OF DEATH		937	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>MD</u> (b) County <u></u>	
(b) Street address <u>2110 N. CALVERT</u>		(c) City or town <u>BALTIMORE</u>	
(c) Hospital or institution:		(d) Street No. <u>2110 N. CALVERT</u>	
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country? <u>NO</u> (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days) <u>LIFE</u>		If yes, name country	
3 (a) FULL NAME <u>LIA MEDORA KLOCH</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>FEM.</u>	5. Color or race <u>WHITE</u>	6 (a) Single, married, widowed, or divorced <u>DIVORCED</u>	
6 (b) Name of husband or wife			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>SEP 15, 1860</u>			
8. AGE: Years <u>83</u>	Months <u>1</u>	Days <u>4</u>	If less than one day hr. min.
9. Birthplace <u>BALTIMORE, MD.</u>			
(Town, county, and state)			
10. Usual Occupation <u>AT HOME</u>			
11. Industry or business			
12. Name <u>FREDRICK OELMAN</u>			
13. Birthplace <u>HANDOVER, GERMANY</u>			
14. Maiden Name <u>DOROTHEA DIETRICH</u>			
15. Birthplace <u>AMSTERDAM, HOLLAND</u>			
16 (a) Informant <u>MISS SOPHIE KLOCH</u>			
(b) Address <u>2110 N. CALVERT ST.</u>			
17 (a) Burial (b) Date thereof <u>10/21/43</u>			
(Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Loudon Park Cem.</u>			
Location <u>Baltimore, Md.</u>			
18 (a) Funeral director <u>WM. J. TICKNER & SONS</u>			
(b) Address <u>Baltimore, Md.</u>			
19 (a) <u>Oct 21 1943</u> <u>William</u>			
20. DATE OF DEATH <u>OCT. 19, 1943</u> <u>8 AM</u>			
21. I certify that death occurred on the date above stated, that I attended deceased from <u>SEP. 1941</u> to <u>OCT. 19, 1943</u> and that I last saw her alive on <u>OCT. 19, 1943</u> .			
Immediate cause of death <u>MYOCARDITIS</u>			
<u>(CHRONIC)</u>			
Due to <u>ARTERIO-SCLEROSIS</u>			
Other Conditions			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(e) Means of injury			
23. Signature <u>John R. Abernethy</u>			
Address <u>3524 Greenmount</u> Date signed <u>9/24/43</u>			

Duration 4 YRS

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09312

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single (married, widowed, or divorced).

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Berkeley Springs)

10. Usual Occupation (Housewife)

11. Industry or business

12. Name (Harrison)

13. Birthplace (W. Va.)

14. Maiden Name (See Bohrer)

15. Birthplace (W. Va.)

16 (a) Informant (Mr. Wilbur E. Johnson)

(b) Address (5006 Norwood Ave.)

17 (a) Burial (b) Date thereof (10/23/43)

(c) Cemetery or crematory (Woodlawn Cem.)

Location (Woodlawn, Md.)

18 (a) Funeral director (WM. J. TICKNER & SONS)

(b) Address (Balto., Md.)

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State (Md.)

(b) County

(c) City or town (Baltimore)

(If outside city or town limits, write RURAL and give town)

(d) Street No. (5006 Norwood Ave)

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH (10/20/43) 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1943 to 10/20 1943, and that I last saw him alive on 10/20 1943.

Immediate cause of death

Gangrene of left arm

Due to

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation (9/10/43)

Major findings of operations

Gangrene of left arm & necrosis

of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address (Md. St. 1000)

Date signed (10/24/43)

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09313
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1633 Darley Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1633 Darley Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Cecelia L. Michel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Widow

6 (b) Name of husband or wife Conrad Michel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1868

8. AGE: Years Months Days If less than one day
74 11 0 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name Joseph Stroup

13. Birthplace Unknown

14. Maiden Name Mary Hutton

15. Birthplace Unknown

16 (a) Informant Mrs. Chas. H. Denn

(b) Address 1633 Darley Ave.

17 (a) Burial (b) Date thereof Oct. 22/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto. Md.

18 (a) Funeral director Philip Stroup Sons

(b) Address 2024 Orleans St.

19 (a) OCT 21 1943
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th/45 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to 10/17 1945, and that I last saw her alive on 10/17 1945.

Immediate cause of death atrophy
Cirrhosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. W. Galloway M. D.
Address 5105 Maryland Rd. Date signed 10/29/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Fritz Krimmer 2700 Harford Rd.
G 09314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09314
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3322 Ellerslie Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Mary Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-15-68

8. AGE: Years 74 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Auditor - B & O R. R.
11. Industry or business

12. Name Edward Grace
13. Birthplace Baltimore Md.
14. Maiden Name Geneva Hubbard
15. Birthplace Baltimore Md.

16 (a) Informant Anna Mary Grace
(b) Address 3322 Ellerslie Ave.

17 (a) Burial (b) Date thereof Oct 23-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave + Fayette St

OCT 21 1943 (c) Huntington Williams Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3322 Ellerslie Ave
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1943, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 20 1943 to Oct 20 1943, and that I last saw him alive on Oct 19 1943.

Immediate cause of death

Cerebral hemorrhage
apoplexy

Due to

Hypertensive cerebrovascular disease

Due to

Other Conditions

Hypertension prostatic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fritz Krimmer
Address Harford Road

Date signed 10/21/43

Duration

4 Ja

5 Ja

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09315
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Elsie Ruth Appleby

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/20

1943 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1943 to 10/20 1943 and that I last saw her alive on 10/20 1943.

Immediate cause of death

Paralytic ileus

Duration

2 days

Due to Peritonitis (Pelvic)

3 days

Due to Pan Hysterectomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/15/43

Major findings of operation: Pelvic -
Grossly enlarged & inflamed
Appendix & Cecum -
of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed 10/20/43

OCT 21 1943

Wm. Williams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09316

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3103 Pelham Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs. 4 mos.

3 (a) FULL NAME

William Burge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Sarah Burge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13-1866

8. AGE: Years 77 Months 1 Days 6 If less than one day hr. min.

9. Birthplace Centralia, Pennsylvania

10. Usual Occupation Coal Miner

11. Industry or business Retired 12 years

12. Name Alfred Burge

13. Birthplace England

14. Maiden Name Nancy Davies

15. Birthplace England

16 (a) Informant Russell C. Burge

(b) Address 3103 Pelham Avenue

17 (a) Burial (b) Date thereof Oct. 22-1943

(c) Cemetery or crematory Odd Fellows

Location Centralia, Pennsylvania

18 (a) Funeral director Burge Funeral Home

(b) Address 3631 Falls Road

19 OCT 21 1943 (b) W. H. Montgomery

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 3103 Pelham Avenue

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19-1943 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Oct 9 1943, and that I last saw him alive on Oct 8 1943

Immediate cause of death Ch. Myocarditis
bronchitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury
23. Signature Charles H. Deane M. D.
Address 3521 Falls Road Date signed Oct 20 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore San Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Fannye Yarrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Raymond S. Yarrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 12 - 1887

8. AGE:

Years

Months

Days

If less than one day

56

5

7

hr.

min.

9. Birthplace

Baltimore Co. Maryland

10. Usual Occupation

At Home

11. Industry or business

FATHER
MOTHER

12. Name

Thomas C. Pearce

13. Birthplace

Maryland

14. Maiden Name

Catherine M. Stabler

15. Birthplace

Maryland

16 (a) Informant

Raymond S. Yarrison

(b) Address

3631 Oak Ave. Lochearn

17 (a)

Burial

(b) Date thereof

Oct. 22 - 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Grind Ridge

Location

Pikesville, Md.

18 (a) Funeral director

Burgess Funeral Home

(b) Address

3631 Halle Road

(c) Date rec'd by registrar

Oct 21 1943

(b)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Lochearn

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3631 Oak Avenue

(If rural, give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/19/43

19

at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1943 to Oct. 19 1943, and that I last saw her alive on Oct. 19 1943.

Immediate cause of death

Coronary artery failure

Due to Ren. metastasis

Due to Lymphatic carcinoma abdominalis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Theodor J. Magiano

Address S. Baltimore San Hosp. signed 10/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *N. Broadway*

(c) Hospital or institution:

Church Home and Hospital(d) Length of stay in hospital or inst. (*year, month, or days*) *26*(e) Length of stay in Baltimore (*year, month, or days*) *24*

3 (a) FULL NAME

Mrs. Alta Howell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

*M*6 (b) Name of husband or wife *Mr. John Howell*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 19, 1901*

8. AGE:

Years

Months

Days

If less than one day

*42**7**0*

hr.

min.

9. Birthplace *Conn.*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Ayers Carlos*13. Birthplace *Conn.*14. Maiden Name *Mary Haulrain*15. Birthplace *New York*16 (a) Informant *Hospital Records*

(b) Address

17 (a) *Burial* (b) Date thereof *10-23-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Monkland Park*Location *Baltimore, Md.*18 (a) Funeral director *Edward Q. Corrington*(b) Address *21 W. 25th St.**Huntington Williams*

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*(c) City or town *1329 Forest Road*
(If outside city or town limits, write RURAL and give town)(d) Street No. *Spencer Point*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 19, 1943* at *2 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 24, 1943* to *Oct 19, 1943*, and that I last saw him alive on *Oct 19, 1943*.

Immediate cause of death

*Pulmonary Embolism*Due to *Phlebotrombosis*

Due to

Other Conditions *Coronary Failure*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: *Same*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? _____
(Specify type of place) While at work?

(e) Means of injury

23. Signature *H. Greiner*Address *Cloud Farm & Hospital* (Date signed *10/19/43*)

Duration

*1 month**8 days*

PHYSICIAN

Underline the cause to which death should be charged statistically.

09319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09319
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

(d) Location

18 (a) Funeral director

(b) Address

19 (a) Signature

(b) Address

(c) Date signed

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated, that I attended deceased from 10/18/43 to 10/19/43, and that I last saw him alive on 10/19/43

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 09320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley Street

(c) Hospital or institution:

Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Lucas

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Catherine Whitney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8-60

8. AGE: Years

8-3

Months

Days

If less than one day

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name William

13. Birthplace Penn.

MOTHER

14. Maiden Name Margaret Knox

15. Birthplace ?

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley Street

17 (a) Burial (b) Date thereof Oct 22 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Baltimore

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 OCT 21 1943 (Date rec'd by registrar) *William M. P.* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1943 at 6 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 - 1943 to Oct 19 - 1943, and that I last saw him alive on Oct 19 - 1943

Immediate cause of death

Edema Lungs

Due to

Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. Bell Hall

Address 1631 E. North Ave Date signed Oct 20 1943 M. D.

Duration

2 days

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9321

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161c

Registered No. G 09321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N. Exeter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mayo
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male 5. Color or race Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 19, 1943
8. AGE: Years Months Days If less than one day
1 hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business
12. Name Charles D. Mayo
13. Birthplace Wilson N.C.
14. Maiden Name Eliza Morning
15. Birthplace Wilson N.C.
16 (a) Informant Charles D. Mayo
(b) Address 13 N. Exeter St
17 (a) Burial, cremation, or removal
(b) Date thereof Oct. 21, 1943
(month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem
Location
18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 322 N. Schroeder St
OCT 21 1943 (c) Huntington Williams, M.D.
(Date and signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 19 at 8:45 A.M.
21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH 9 stems
monatorem

Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?
(d) Means of injury
23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 20, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09322	
CERTIFICATE OF DEATH		Registered No. 83a	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address 604 N. Bethel St (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days)		2. USUAL RESIDENCE OF DECEASED: (a) State Md (b) County (c) City or town Baltimore (If outside city or town limits, write RURAL and give town) (d) Street No. 604 N. Bethel St (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country	
3 (a) FULL NAME Lillian Goodwin 3 (b) If veteran, name war 3 (c) Social Security Account No.		MEDICAL CERTIFICATION	
4. Sex F. 5. Color or race C. 6 (a) Single, married, widowed, or divorced S 6 (b) Name of husband or wife 6 (c) If alive, give age years		20. DATE OF DEATH Oct. 18 1943 at P.M.	
7. Birth date of deceased (mo., day, yr.) Jan. 2, 1907 8. AGE: Years 36 Months 9 Days If less than one day hr. min. 9. Birthplace Smithfield Va (town, county, and state) 10. Usual Occupation Domestic 11. Industry or business		21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1943 to Oct 15 1943 and that I last saw her alive on Oct 15 1943 Immediate cause of death Cerebral Hemorrhage Due to Malignant Hypertension Due to Other Conditions (Include pregnancy within 3 months of death) Date of operation Major findings of operation: of autopsy:	
12. Name Charles Goodwin 13. Birthplace Va. 14. Maiden Name Mary Briggs 15. Birthplace Va. 16 (a) Informant Alice Goodwin (b) Address 604 N. Bethel St 17 (a) Burial (b) Date thereof 10/21/43 (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory Mt Calvary Location 18 (a) Funeral director Wm. A. Wilson (b) Address 1000 Broadway Ave 19 (a) (b) Registrar (Date rec'd by registrar) (Signature)		22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence at M (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) (e) Means of injury 23. Signature Ralph W. Reuther, Jr. Address 426 N. Glen Date signed 10/18/43	

OCT. 21 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09323

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

CARRIE WILLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2-3-21

8. AGE:

Years

Months

Days

If less than one day

22

8

15

hr.

min.

9. Birthplace

VA

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Willis

13. Birthplace

MD

14. Maiden Name

CARRIE WILLIS

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/21/43

(c) Cemetery or crematory

mt. Calvary

Location

18 (a) Funeral director

Elroy O. Wilson

(b) Address

1000 Brantley Ave

19 (a)

(b)

(Date rec'd by registrar)

Huntington, West Virginia

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1101 Harlem Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1943, to Oct 18 1943, and that I last saw him alive on Oct 18 1943.

Immediate cause of death

Respiratory failure

Due to

anemia and cord

Due to

subacute fellow atrophy
cause unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Sharon Genein

Genein

Address

Johns Hopkins Hospital

Date signed

M. D.

OCT 21 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4423 59324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09324
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **Wilbert Samuel Milburn**

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **8-22-43**

8. AGE: Years Months Days If less than one day
21 28 hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **Wilbert Johnson**

13. Birthplace

Md

14. Maiden Name **Evelyn Thomas**

15. Birthplace

MASS.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) **Burial** (b) Date thereof **10/22/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Not Calvary

Location

18 (a) Funeral director **Elroy O. Wilson**

(b) Address

100 Brantley Ave

19 (a) **OCT 21 1943** (b) **Huntington Williams, Md**

VS 154

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **413 N CAROLINE**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 20 1943** at **100 A** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 4 1943** to **Oct 20 1943**, and that I last saw him alive on **Oct 20 1943**.

Immediate cause of death **Respiratory
Collapse**

Due to **Severe Heart
System Lesion**

Due to

Other Conditions **Diabetes
Dysentery; Dehydration**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **John R. Birmingham**

J.H.H. Date signed **10-20**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Redwood & Sun St.*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County
(c) City or town *Balto., Ind.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *3809 Chatham Rd*
(If rural give location)
(e) Citizen of foreign country? *NO* (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Boy Mullinix
3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 7, 1943*

8. AGE: Years Months Days If less than one day
13 hr. min.

9. Birthplace *Univ Hospital, Balto, Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Clarence H. Mullinix*

13. Birthplace *Balto., Ind.*

14. Maiden Name *Ruth E. Smith*

15. Birthplace *Balto.,*

16 (a) Informant *Clarence H. Mullinix*

(b) Address *3809 Chatham Rd*

17 (a) *Burial* (b) Date thereof *Oct 21/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Woodlawn*
Location *Woodlawn, Ind.*

18 (a) Funeral director *Harry H. Witzke*

(b) Address *4401 Edmonston Rd*

19 (a) *OCT 21 1943* (b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/20 1943* at *10/20/43*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/18 1943* to *10/20 1943*, and that I last saw him alive on *10/20 1943*.

Immediate cause of death *Dehydration*

Due to *Diarrhea & prematurity*

Other Conditions *Sclerosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *S. L. S. ranch.*

Address *Univ. Hosp.* Date signed *10/21/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correctness. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09326

T.N 82145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09326
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

A
Hugh Neill

3 (b) If veteran, name war

3 (c) Social Security Account
No. 27-14-3709

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Marcelna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1894

8. AGE: Years Months Days If less than one day
48 8 10 5 hr min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
MOTHER

12. Name Hugh Neill

13. Birthplace Maryland

14. Maiden Name Annie Hudson

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 10/22/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western

Location Edmondson - Longwood ave

18 (a) Funeral director William M Marek

(b) Address 715 Light St

19 OCT 21 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Brooklyn (Baltimore)
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3830 Brooklyn Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1943, 10 PM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 6-19 1943, to 10-19 1943,

and that I last saw him alive on 10-19 1943.

Immediate cause of death

Due to Post Operative Shock
Hemothorax
Pneumonia etc
Due to Tuberculosis & emphysema
broncho-pneumal abscess
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-15-43

Major findings of operation etc

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas R. Neill M. D.

Address Baltimore City Hosp Date signed 10-19-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

441912
G 09327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09327
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **John BAUGH**

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

BLANCH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1-6-77**

8. AGE: Years Months Days If less than one day

66

9

12

hr.

min.

9. Birthplace

VA

(Town, county, and state)

10. Usual Occupation

PAINTER

11. Industry or business

12. Name **John BAUGH**

13. Birthplace

14. Maiden Name **Elizabeth Coleman**

15. Birthplace

16 (a) Informant **Records**

(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **10/21/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Mt. Calvary Cem.**
Location **A. A. County**

18 (a) Funeral director **Layner Sanders**

(b) Address **1410 E. Preston St**

19 (a) **OCT 21 1943** (b) **Washington** Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**

(If outside city or town limits, write RURAL, and give town)

(d) Street No. **327 E. 23rd St**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 18** 1943, at **9:45** M

21. I certify that death occurred on the date above stated; that I attended deceased from **9/27** 1943 to **10/18** 1943, and that I last saw him alive on **10/18** 1943

Immediate cause of death

**Coronary failure
pulmonary embolism?**

Due to

Due to

Other Conditions

**gastrointestinal
- arteries & veins**

(Include progress within months of death)

Date of operation **7/28/43**

Major findings of operations: **operated
coronary & stomach**

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **W. W. Chambers**

Address **Johns Hopkins Hospital** Date signed **10/19/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

909328

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09328
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2006 Sulgrave Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1/2

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

3 (a) FULL NAME

John A. Sebelin

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

Anna E. Sebelin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1868

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore

10. Usual Occupation

Meat Packer

11. Industry or business

Retired.

12. Name

John A. Sebelin

13. Birthplace

Germany

14. Maiden Name

Don't know

15. Birthplace

Germany

16 (a) Informant

Mrs. Helmbright

(b) Address

2006 Sulgrave Ave

17 (a) Burial

(b) Date thereof 10/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Landon Park

Location

Baltimore, Md

18 (a) Funeral director

Wm. J. Furness, Jr.

(b) Address

2008 Orleans St

19 (a)

(Date rec'd by registrar)

10/21/43

OCT 21 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Balts

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2006 Sulgrave Ave

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1943 at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1941 to Oct 18 1943 and that I last saw him alive on Oct 18 1943

Immediate cause of death

Mild insufficiency

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

303 Oak Hill Dr

Date signed

10/21/43

78 Dr. Wollenschen Rd. Oct 21 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09329

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution Juii Hosp of Balt.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) 80

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3229 Fleet St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John R Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Unmarried

6 (b) Name of husband or wife Mary J Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1867

8. AGE: Years 80 Months 5 Days 29
If less than one day hr. 18 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation machinist

11. Industry or business Retired

12. Name Christian Frank

13. Birthplace Germany

14. Maiden Name Sophie Kessel

15. Birthplace Germany

16 (a) Informant J. E. Frank

(b) Address 11 Lexington Ave

17 (a) Burial (b) Date thereof Oct 23
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location John City

18 (a) Funeral director Wm. H. Williams

(b) Address 2005 Orleans

19 (a) OCT 21 1944
(Date rec'd by registrar) Wm. H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/43 19 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17/43 19 to 10/20/43 19 and that I last saw him alive on 10/19/43 19.

Immediate cause of death

arteriosclerotic Disease with infarction

Due to

Due to

Other Conditions Pumping Prost. Hypert.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry D. Shuman

Address Juii Hosp Date signed 10/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *St Joseph's Hospital*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *86 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1030 M & Allen Court*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME *Henry Kansler*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife *Clementine Kansler*

6 (c) If alive, give age *82 years*

7. Birth date of deceased (mo., day, yr.) *June 7, 1857*

8. AGE: Years Months Days If less than one day

86

4

13

hr.

min.

9. Birthplace *Baltimore Md.*

(Town, county, and state)

10. Usual Occupation *retired produce*

11. Industry or business *merchant*

12. Name *Chas Kansler*

13. Birthplace *Balto*

14. Maiden Name *Annie Salbach*

15. Birthplace *Balto*

16 (a) Informant *Clementine Kansler*

(b) Address *1030 M & Allen Court*

17 (a) *Burial* (b) Date thereof *Oct 23*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt Carmel*

Location *Cota*

18 (a) Funeral director *John Jellrich*

(b) Address *200 S Orleans*

19 (a) *OCT 21 1943* (b) *William M. Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-20-43* 19 *at 10:00 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-18 1943* to *10-20 1943*.

that I last saw him alive on *10-20 1943*.

Immediate cause of death *Cerebral Hemorrhage*

Duration

Due to *arteriosclerosis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *William M. Registrar*

M. D.

Address *St Joseph's Hospital* Date signed *10-20-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		6.09331	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>MD</u> (b) County <u>15</u>	
(b) Street address <u>6025 Stanton Ave</u>		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution:		(d) Street No. <u>1410 Forge Ave</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country? <u>No</u> , (Yes or No) If yes, name country.	
(e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>			
3 (a) FULL NAME <u>Nancy Lee Skipper</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>female</u>	5. Color or race <u>W.</u>	6 (a) Single, married, widowed, or divorced <u>single</u>	
6 (b) Name of husband or wife		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>Jan 10, 1942</u>			
8. AGE: Years <u>1</u> Months <u>9</u> Days <u>11</u> If less than one day hr. min.			
9. Birthplace <u>Baltimore</u> (Town, county, and state)			
10. Usual Occupation			
11. Industry or business			
12. Name <u>Charles W. Skipper</u>			
13. Birthplace <u>Balto, Co. MD</u>			
14. Maiden Name <u>Mary A. Brown</u>			
15. Birthplace <u>Baltimore, MD</u>			
16 (a) Informant <u>Charles W. Skipper</u>			
(b) Address <u>1410 Forge Ave</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>Oct 1943</u> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Staten</u> Location <u>Staten, N.Y.</u>			
18 (a) Funeral director <u>Chenoweth & Sonoran</u>			
(b) Address <u>3615-17 Chestnut Ave</u>			
19 (a) <u>1943</u> (b) <u>Washington Williams, M.D.</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Oct 21</u> 19 <u>43</u> , at <u>A.</u> M.			
21. I certify that death occurred on the date above stated; that I attended deceased from <u>10/19</u> 19 <u>43</u> , to <u>10/21</u> 19 <u>43</u> , and that I last saw him alive on <u>10/20</u> 19 <u>43</u> .			
Immediate cause of death <u>Enteric Colitis, acute</u>			
Due to <u>Ricketts</u>			
Due to <u>Immunodeficiency</u>			
Other Conditions <u>No treatment.</u>			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy.			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(e) Means of injury			
23. Signature <u>Staten</u>			
Address <u>40204, Charles</u> Date signed <u>10/21</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09332
Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address *N. Broadway*
(c) Hospital or institution: *Church Home and Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *6*
(e) Length of stay in Baltimore (yrs., mos., or days) *56*

2. USUAL RESIDENCE OF DECEASED:
(a) *St. Mary* (b) County *MD*
(c) City or town *Baltimore* (If outside city or town limits, write RURAL and give town)
(d) Street No. *1615 Sulgrave Ave* (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Mr. Phillip Rich*

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *M* 5. Color or race *N* 6 (a) Single, married, widowed, or divorced. *M*

6 (b) Name of husband or wife *Mary R. Rich*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 4, 1897*

8. AGE: Years *56* Months *6* Days *16* If less than one day, hr. *18* min.

9. Birthplace *Maryland* (Town, county, and state)

10. Usual Occupation *Sexton of Church*

11. Industry or business

12. Name *Peter Rich*

13. Birthplace *MD*

14. Maiden Name *Kate Mulberry*

15. Birthplace *MD*

16 (a) Informant *Hospital Record*

(b) Address

17 (a) *Burial* (b) Date thereof *Oct 23/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Woodlawn*
Location

18 (a) Funeral director *Chenoweth & Son*

(b) Address *3615-17 Chestnut Ave*

19 (a) *10/21/43* (b) *Huntington Williams, MD*

(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 20 1943*, at *10:40* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 15 1943*, to *Oct 20 1943*, and that I last saw him alive on *Oct 20 1943*.

Immediate cause of death

Uremia
Bronchopneumonia

Due to

Hypertension C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *W. H. H. H.*

Address *Church Home and Hospital* Date signed *10/20/43*

Duration

6 days
6 days

?

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09333
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 410 S. Calhoun St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joyce Gibson

3 (b) If veteran, name war

3 (c) Social Security account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26-43

8. AGE: Years Months Days If less than one day

3 weeks 25 hr. min.9. Birthplace BALTIMORE

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name SIDNEY A GIBSON13. Birthplace BALTO., MD.14. Maiden Name MILDRED LATHE15. Birthplace BALTO., MD.16 (a) Informant SIDNEY A GIBSON(b) Address 410 S CALHOUN ST.17 (a) BURIAL (b) Date thereof Oct 22-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt Olivet
Location Balto md.18 (a) Funeral director Frederick A. Cole(b) Address 1200 W. Lombard St
Huntington Williams, M.D.OCT 21 1943
Date of death (month) (day) (year) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 410 S. Calhoun St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1943, at 9:00 AM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH mitral insufficiencyLobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.Date signed October 20, 1943
Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

43403334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09334

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State D. C. (b) County

City or town WASHINGTON

(If outside city or town limits, write RURAL and give town)

7-5 Street No. 1233 31st NW

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

MURRAY M Stewart Jr.

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

AMI

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 10-12-95

8. AGE: Years 48 Months - Days 9 If less than one day hr. min.

9. Birthplace

GA

(Town, county, and state)

10. Usual Occupation

AGRICULTURE

11. Industry or business

U.S. Dept

FATHER
MOTHER

12. Name MURRAY M. STEWART

13. Birthplace

GA

14. Maiden Name

HARRIET JONES

15. Birthplace

N.C.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10-21-43

(Burial, cremation, or re-moval) (month) (day) (year)

(c) Cemetery or crematory

Location Washington D.C.

18 (a) Funeral director

Wm. J. [unclear]

(b) Address

1000 [unclear]

06T 21 1943

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1943, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1943 to Oct 21 1943, and that I last saw him alive on Oct 21 1943.

Immediate cause of death

1. Pulmonary embolism

Due to operations (sympathectomy) for hypertension

Other Conditions hypertension

(Include pregnancy within 3 months of death)

Date of operation 9/14/43, 10/4/43, and 10/24/43

Major findings of operations: Removal of sympathetic ganglia

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. Sloan

Address J. H. Sloan

Date signed 10/21/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09335
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 902 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Hilda Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 4, 1930

8. AGE: Years Months Days If less than one day

12 11 10 14 hr. min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

MOTHER: FATHER:

12. Name Paul Eney Jones

13. Birthplace

Md

14. Maiden Name Carrie Simms

15. Birthplace

Md

16 (a) Informant Carrie Jones (M)

(b) Address 902 Warner St

17 (a) Burial (b) Date thereof 10-22-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Co

(b) Address 108 W. Montgomery St

(c) Funerary (d) Funerary

OCT 21 1943 Funerary

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1943 at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1943 to Oct 18 1943, and that I last saw him alive on Oct 18 1943.

Immediate cause of death

Malignant tumor of
Mediastinum

Due to

Due to

Other Conditions

Chronic Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles J. Woodland
Address 861 Date signed 10/20/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09336

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Lexington

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 204

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Miss Mary Bessenkamp

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

About 6 1/2

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

End Bessenkamp

13. Birthplace

md-

14. Maiden Name

Mary Herlein

15. Birthplace

md

16 (a) Informant

Augusta Bessenkamp

(b) Address

2907 E. Monument St.

17 (a)

Burial

(b) Date thereof

10/23/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md.

18 (a) Funeral director

H. W. Meeks and Son

(b) Address

805 N. Calvert Street

(c) Date rec'd by registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD.

(b) County

(c) City or town

Balt.

(d) Street No.

2907 E. Monument St.

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 20

1943, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1943, to Oct 20, 1943, and that I last saw him alive on Oct 20, 1943.

Immediate cause of death

Cardiac Failure

Due to

Hypertensive cardiac vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Marion K. Adair, M.D.

Address

Mercy Hosp.

Date signed 10/20/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09337
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Redwood & Green*
(c) Hospital or institution: *Community*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *13 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County
(c) City or town *Bethesda*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2929 Dillon St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John W. Malone
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Single*
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 9 - 1863*
8. AGE: Years *80* Months *4* Days *11* If less than one day hr. min.

9. Birthplace *Bethesda, Md.*
(Town, county, and state)

10. Usual Occupation *Carpenter*

11. Industry or business *Retired*

12. Name *Thomas J. Malone*

13. Birthplace *Wales*

14. Maiden Name *Mary E. Casey*

15. Birthplace *Ireland*

16 (a) Informant *Joseph J. Malone*

(b) Address *4504 Oriole Ave*

17 (a) *Burial* (b) Date thereof *Oct 23 - 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Cross*
Location *Harford Rd.*

18 (a) Funeral director *John G. Moran*

(b) Address *300 E. Balto. St.*

19 (a) (b)
(Signature of registrar) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 20 1943* at *7:49 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 8 1943* to *Oct 10 1943*, and that I last saw him alive on *Oct 20 1943*.

Immediate cause of death *Pulmonary malignancy?*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *M. V. Palmer* M. D.

Address *University Heights* Date signed *10/24/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 21 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09338

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, Oct 19 1943, and that I last saw him alive on Oct 17 1943.

Immediate cause of death: Coronary Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09339
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **24 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **24 days**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County **Anne Arundel**
(c) City or town **Annapolis**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3 Carroll Street**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME **HALL CULLY**

- 3 (b) If veteran, name war **Sp. Am. War** 3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **Col.** 6 (a) Single, married, widowed, or divorced.

- 6 (b) Name of husband or wife **Carrie Smith** 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **9/18/1875**

8. AGE: Years **68** Months **1** Days **2** If less than one day hr. min.

9. Birthplace **Annapolis, Md.**

(Town, county, and state)

10. Usual Occupation **None-Last worked 10 yrs. ago**

11. Industry or business **None**

12. Name **Cully, James J.**

13. Birthplace **? Md.**

14. Maiden Name **Harriet Hall**

15. Birthplace **? Md.**

- 16 (a) Informant **Records, U. S. Marine Hosp.**

- (b) Address **Baltimore, Md.**

- 17 (a) **Buried** (b) Date thereof **Oct 23, 43**
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory **National Cemetery**
Location **West of Extended Plaza**

- 18 (a) Funeral director **E. J. Hays**

- (b) Address **45 North Street at Corner**

- 19 **1943** (b) Registrar
(Date filed by registrar)

VS 116

Huntington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **Oct. 20,** 19 **43**, at **7:30** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 26, 1943** to **Oct. 20, 1943**, and that I last saw him alive on **Oct. 20, 1943**.

Immediate cause of death **Marked coronary sclerosis with small fresh infarct.**

Duration
Unk.

Due to

Due to

Other Conditions **Generalized arterio-sclerosis** **Unk.**

(Include pregnancy within 3 months of death)

Date of operation **10/8/43-Amputation rt. leg & biopsy popliteal artery**
Major findings of operation: **Arteriosclerotic gangrene of the rt. leg.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy. **As above**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide **No**
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify place of injury)

- (e) Means of injury **As above**

23. Signature **[Signature]**

Address **Baltimore, Md.**

Date signed **10/20/43**

Va-13756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09340
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **20 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **Since 9/29/43**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maine** (b) County
(c) City or town **Portland**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **35 Garrison Street**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME **JOHN O. HALL, Lieut. Comdr., U.S. Coast Guard (T) (R)**

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Widowed**

6 (b) Name of husband or wife **Anna Jensen**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **10/25/1873**
8. AGE: Years **69** Months **11** Days **24** If less than one day
hr. min.

9. Birthplace **Rockland, Me.**
(Town, county, and state)

10. Usual Occupation **Lt. Commander (Pilot)**

11. Industry or business **(C.G. Reserves)**

12. Name **Hiriam Hall, Jr.**

13. Birthplace **Rockland, Me.**

14. Maiden Name **Susan E. Snow**

15. Birthplace **South Thomas**

16 (a) Informant **Records of U.S. Marine Hosp.**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **10/24/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location **Portland, Me**

18 (a) Funeral director **A. Lee Oden**

(b) Address **4644 York Road**

19 (a) (b) **Huntington Williams, M.D.**
(Date rec'd by registrar) Registrar

OCT 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 19, 1943** at **3:00 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept. 29, 1943** to **Oct. 19, 1943** and that I last saw him alive on **Oct. 19, 1943**.

Immediate cause of death **Bronchiogenic carcinoma of the left lung with extensive metastases**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation **10/9 & 10/16/43**
Two thoracentesis operations
Major findings of operation: **As above**

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature **[Signature]**

Address **Baltimore, Md.** Date signed **10/19/43**

48277

Duration
10 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09341
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

Caton & Wilkins Rd.

(c) Hospital or institution:

St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

25

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

George Vogt (Vogt)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 21 - 1899

8. AGE:

Years

Months

Days

If less than one day

63

10

—

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Retired Fireman

11. Industry or business

Balto. Fire Dept

FATHER
MOTHER

12. Name

Fredrick Vogt

13. Birthplace

Balto. Ind.

14. Maiden Name

Wilhemina Rodriguez

15. Birthplace

Germany

16 (a) Informant

Minnie J. Kettel

(b) Address

2502 Wilkins Ave

17 (a)

Burial

(b) Date thereof

Oct 25 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Our Cathedral

Location

Baltimore Ind.

18 (a) Funeral director

George L. Schwaab

(b) Address

2101 Frederick Ave

19 (a)

(b)

(Date rec'd by registrar)

Registrar

OCT 22 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

Baltimore

(c) City or town

Arbutus

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5723 - 1st Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/21 1943 at 4:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1943 to 21 1943.

and that I last saw him live on 21 1943.

Immediate cause of death Perforated

Duration

Due to Perforated Cecum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Perforated

cecum - perforation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. T. Muse

Address: St. Agnes Hosp.

Date signed 10/21/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09342
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 1 1943, to OCT 21 1943, and that I last saw him alive on OCT 21 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09343		CERTIFICATE OF DEATH 95c		G 09343		Registered No.	
1. PLACE OF DEATH:					2. USUAL RESIDENCE OF DECEASED:				
(a) Baltimore City, Maryland					(a) State <u>Md.</u> (b) County				
(b) Street address <u>St James Apts.</u>					(c) City or town <u>Baltimore</u>				
(c) Hospital or institution <u>Charles and Centre Sts</u>					(d) Street No. <u>Charles & Centre St.</u>				
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>11</u>					(e) Citizen of foreign country? (If rural give location) (Yes or No)				
(e) Length of stay in Baltimore (yrs., mos., or days) <u>539</u>					If yes, name country				
3 (a) FULL NAME <u>Louise Natoli Pearson</u>					MEDICAL CERTIFICATION				
3 (b) If veteran, name war					20. DATE OF DEATH <u>Oct. 21 - 1943</u> at <u>9:10</u> M				
3 (c) Social Security Account No. <u>None</u>					21. I certify that death occurred on the date above stated; that I attended deceased from <u>Aug 20 1942</u> to <u>Oct 21 1943</u> , and that I last saw her alive on <u>Oct 21 1943</u> .				
4. Sex <u>F</u>					5. Color or race <u>W.</u>				
6 (a) Single, married, widowed, or divorced <u>W.</u>					6 (b) Name of husband or wife <u>Edward Pearson</u>				
6 (c) If alive, give age <u>0</u> years					6 (d) If alive, give age <u>0</u> years				
7. Birth date of deceased (mo., day, yr.) <u>Aug. 3 - 1850</u>					8. AGE: Years <u>27</u> Months <u>2</u> Days <u>18</u> hr. min.				
9. Birthplace <u>Ill.</u> (Town, county, and state)					10. Usual Occupation <u>at home</u>				
11. Industry or business <u>Self</u>					12. Name <u>Charles Barnes</u>				
13. Birthplace <u>Ill.</u>					14. Maiden Name <u>Margaret Bowman</u>				
15. Birthplace <u>Ill.</u>					16 (a) Informant <u>Louise Pearson</u>				
16 (b) Address <u>St James Apts.</u>					17 (a) <u>Burial</u> (b) Date thereof <u>Oct 22 - 43</u>				
17 (c) Cemetery or crematory <u>London Ave.</u>					18 (a) Funeral Director <u>Wm. John Ene</u>				
18 (b) Address <u>at home</u>					19 (a) <u>OCT 22 1943</u> (Date rec'd by registrar)				
19 (b) <u>Huntington Williams, M.D.</u> Registrar					22. If death was due to external causes, fill in the following:				
20. DATE OF DEATH <u>Oct. 21 - 1943</u> at <u>9:10</u> M					(a) Accident, suicide, or homicide				
21. I certify that death occurred on the date above stated; that I attended deceased from <u>Aug 20 1942</u> to <u>Oct 21 1943</u> , and that I last saw her alive on <u>Oct 21 1943</u> .					(b) Date of occurrence at M				
Immediate cause of death <u>Arteriosclerosis</u>					(c) Where did injury occur? (City or town) (County) (State)				
Due to <u>Heart Condition</u>					(d) Did injury occur about home, on farm, industrial place, in public place? While at work?				
Other Conditions					(e) Means of injury				
(Include pregnancy within 3 months of death)					23. Signature <u>James F. Pearson M.D.</u>				
Date of operation					Address <u>375 W. Elder St.</u> Date signed <u>Oct 21 - 43</u>				
Major findings of operation:					M. D. <u>Oct 21 - 43</u>				
of autopsy					Date signed				

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G 09345

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Greenwing & Belvedere Aves
(c) Hospital or institution: Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenwing Aves
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Isaac Rofsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1891

8. AGE: Years

72

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Ben Rofsky

13. Birthplace

Russia

14. Maiden Name

Bessie

15. Birthplace

Russia

16 (a) Informant

Isaac Rofsky

(b) Address

4118 Oakford Ave

17 (a)

Bureau

(b) Date thereof

10-22-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Rosevale

Location

Plot 10 & Hamilton Ave

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1139 E. Baltimore St

19

OCT 22 1943

Registrar

VS 134

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-20

1943 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1937, to 10-20 1943, and that I last saw him alive on 10-19 1943.

Immediate cause of death

Arteriosclerosis
Hypertension

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William Lewis

M. D.

Address

Levindale

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09346
Registered No. 46E

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2706 Baker St

(c) Hospital or institution: _____

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County _____

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2706 Baker St
(If rural give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

Frank R. Gerstunger

3 (b) If veteran, name war _____

3 (c) Social Security Account No. _____

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary G. Gerstunger

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

Jan. 8-1880

8. AGE:

Years

Months

Days

If less than one day

63

9

11

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Painter (Retired)

11. Industry or business

B & O. R.R.

12. Name

Fredrick R. Gerstunger

13. Birthplace

Germany

14. Maiden Name

Marie E. Hannibal

15. Birthplace

Germany

16 (a) Informant

Mrs. Mary G. Gerstunger

(b) Address

2706 Baker St

17 (a) Burial

(b) Date thereof

Oct. 22-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cr.

Location

Woodlawn Md

18 (a) Funeral director

Geo. L. Beyer Jr

(b) Address

1512 Hollins St

19 (a)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1943, at 9:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 1943, to Oct 19 1943, and that I last saw him alive on Oct 16 1943.

Immediate cause of death

Myocardial failure
Adeno-Carcinoma
of Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/18/41

Major findings of operation: Carcinoma of
Sigmoid

of autopsy:

Duration

2 1/2 hr

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?

(Specify type of place)

(e) Means of injury

23. Signature John F. Coakley

Address 24 H. Fulton Ave Date signed 10/21/43

OCT 22 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

47

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09347

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert St.

(c) Hospital or institution:

Mercy Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1220 McCallum St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Edward Gough.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1890

8. AGE: Years Months Days

53 yrs. 9 21

If less than one day

hr.

min.

9. Birthplace Balto.

(Town, county, and state)

10. Usual Occupation Days Work.

11. Industry or business

12. Name Frank Gough

13. Birthplace Balto.

14. Maiden Name Lucy Bennet.

15. Birthplace Balto.

16 (a) Informant Deceased.

(b) Address

17 (a) Burial (b) Date thereof Oct 21, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto.

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 OCT 22 1943 (b) Huntington, W. Va.

Date of death

Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1943, at 6 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/29 1943 to 10/16 1943 and that I last saw him alive on 10/16 1943

Immediate cause of death

Venemia.

Duration

2 mos.

Due to Hypertensive C. I. Disease.

Chronic Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. Queen

Address Mercy Hosp. Date signed 10/16/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09348

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09348

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

25 **5** **1**

If less than one day

hr. min.

9. Birthplace

Maryland

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) **Burial**

(b) Date thereof

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

(c) Means of injury

23. Signature

Address

Date signed

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County(c) City or town **Baltimore**(d) Street No. **2225 N. Howard St**

(e) Citizen of foreign country? (Yes or No)

If yes, name country

20. DATE OF DEATH **Oct. 19 1943**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 12 1943** to **Oct 19 1943** and that I last saw **him** alive on **Oct 19 1943**

Immediate cause of death

Due to **Pneumonia**Due to **Self-inflicted intoxication**Other Conditions **Acute hemorrhage from**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature **Chahem Gordon**Address **Johns Hopkins Hospital**Date signed **10-19-43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09349

442790

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09349
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address:

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 904 Argyle Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

James Byrd

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

married6 (b) Name of husband or wife Theresa6 (c) If alive, give age 24 years7. Birth date of deceased (mo., day, yr.) 3-26-14

8. AGE:

Years

Months

Days

If less than one day

29624

hr.

min.

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

Truck Driver

11. Industry or business

12. Name Horace Byrd.

13. Birthplace

md.14. Maiden Name Rebecca Williams

15. Birthplace

va

16 (a) Informant

Rebecca

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or place of burial

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

(b) Date of burial

(c) Date of cremation

(d) Date of interment

(e) Date of inhumation

(f) Date of entombment

(g) Date of exhumation

(h) Date of reinterment

(i) Date of reinterment

(j) Date of reinterment

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-20-1943 at 4:20 M21. I certify that death occurred on the date above stated; that I attended deceased from Oct-12-1943 to Oct-20-1943 and that I last saw him alive on Oct-20-1943Immediate cause of death Myocardial FailureDue to Hypertensive Cardio-Vascular DiseaseDue to NephrosclerosisOther Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John R. Birmingham

Address

J.H.H.Date signed 10-21Duration
3 wks2 yrs. +2 yrs. +3 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Complete age is especially important. Physicians: please write the causes of death clearly and legibly.

09350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09350
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **926 Bennett Place**
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) **18-1**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Gertrude Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

Female **Colored**

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 25, 1907**

8. AGE: Years

Months

Days

If less than one day

36**35****3****26**

hr.

min.

9. Birthplace **Charles Co., Md.**

(Town, county, and state)

10. Usual Occupation **Housewife**

11. Industry or business

12. Name **John Milton**13. Birthplace **Md.**

14. Maiden Name

15. Birthplace **Md.**16 (a) Informant **Mr. James Stevens**(b) Address **926 Bennett Place**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **10-25-43**

(month) (day) (year)

(c) Cemetery or crematory **Arbutus Mem. Park**Location **Balt. Co., Md.**18 (a) Funeral director **Mrs. Frances A. Hemsley**(b) Address **578 W. Biddle St.**(c) **Huntington Williams, M.D.**

(d) Date rec'd by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **926 Bennett Place**

(e) Citizen of foreign country? (If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 21, '43** 19 **43** at **4 A.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 15** 19 **43** to **Oct 21** 19 **43** and that I last saw him alive on **Oct 21** 19 **43**.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at

M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09351

BALTIMORE CITY HEALTH DEPARTMENT

G 09351

CERTIFICATE OF DEATH **48B**

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address **808 Tyson Street**
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **11-3**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Eleanor Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Cobored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 20, 1900**8. AGE: Years **43** Months **5** Days **-** If less than one day hr. min.9. Birthplace **Virginia**

(Town, county, and state)

10. Usual Occupation **Domestic**

11. Industry or business

12. Name **Lee Hatchett**13. Birthplace **Va.**14. Maiden Name **Jennie Bagwell**15. Birthplace **Va.**16 (a) Informant **William Robinson**(b) Address **808 Tyson St.**17 (a) **Burial** (b) Date thereof **10-20-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Mt. Auburn Cem/**
Location **Baltimore, Md.**18 (a) Funeral director **Mrs Frances A. Hemsley**(b) Address **578 W. Biddle St.****OCT 22 1943** **Huntington Williams, M.D.**
(Date rec'd by registrar) Registrar

VS 138

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **808 Tyson Street**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 20, '43** 19 at **4:15M**21. I certify that death occurred on the date above stated; that I attended deceased from **Mar 17 1943** to **Oct 20 1943** and that I last saw her alive on **Oct 20 1943**

Immediate cause of death

uterine Cancer

Duration

over a year

Due to

Due to

Other Conditions **none**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **H. K. Pettigrew**

M. D.

Address **817 Hamilton Ave** Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09352
Registered No.

1. PLACE OF DEATH:

(a) City or town Baltimore City, Maryland
(b) Street address 1627 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Thomas E. Myers

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mrs. Lillie Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1879

8. AGE: Years 63 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Joseph Myers

13. Birthplace Md.

14. Maiden Name Eleanor Mitchell

15. Birthplace Md.

16 (a) Informant Mrs. Lillie Myers

(b) Address 1627 W. Lanvale St.

17 (a) Burial (b) Date thereof 10-24-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hopkins Chapel
Location Howard Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) Oct 22 1943 Thurston Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20, '43 19 43, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1943 to 10/20 1943, and that I last saw him alive on 10/19 1943

Immediate cause of death

Chronic Bright's Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. H. Williams

Address 450 W. Biddle St. Date signed 10/21/43

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

9353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. G 09353

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Baltimore, Maryland
 (c) Hospital or institution:
Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1714 Sexton Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

HARRY C. GRIMES

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. 705-10-2085

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife LOTTIE GRIMES6 (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) AUG. 30, 1869

8. AGE:

Years

Months

Days

If less than one day

74

1

20

hr.

min.

9. Birthplace BALTIMORE, MD.

(Town, county, and state)

10. Usual Occupation RETIRED MACHINIST11. Industry or business B & O R.R.FATHER
MOTHER12. Name JAMES GRIMES13. Birthplace MD.14. Maiden Name MARGARET HANN15. Birthplace MD.16 (a) Informant LOTTIE GRIMES(b) Address 1714 SEXTON ST.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

OCT 22 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

12:45 P.

20. DATE OF DEATH October 20, 1943 at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallerstein M.D.Date signed 10-21-43

Medical Examiner.

9354

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09354
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 002

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1038 Hollins St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

SOLOMON F. TYLER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. NONE

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife MAE A. TYLER

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) FEB. 26 - 1872

8. AGE:

Year

Months

Days

If less than one day

76

7

24

5

hr.

min.

9. Birthplace BALTIMORE, MD.

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER

12. Name SOLOMON TYLER

13. Birthplace BALTO., MD.

MOTHER

14. Maiden Name ELIZABETH -

15. Birthplace BALTO., MD.

16 (a) Informant WALTER S. TYLER

(b) Address 2019 E. OLIVER ST.

17 (a)

Burial

(b) Date thereof

Oct 23, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Cedar Hill Cem

Location

A.A. Co. Md

18 (a) Funeral director

Roth & B.M. Walters

(b) Address

1001 N. Charles St.

(Date Rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1943, at 2:45 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia lobes, left

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. W. Wallenhausen M.D.

Medical Examiner.

Date signed 10-21-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The age is especially important. Physicians: please write the causes of death clearly and legibly.

09355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09355

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1376 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John C. Cornes

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-6597

4 Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

Core Mae Cornes

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.)

Sept 5-1900

8. AGE:

Years 43

Months 1

Days 16

If less than one day hr. min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Regman

11. Industry or business

Ship Yard

12. Name

John A. Cornes

13. Birthplace

Baltimore County Md

14. Maiden Name

Mary J. Nash

15. Birthplace

Frederick County Md

16 (a) Informant

Core Mae Cornes

(b) Address

1376 Hollins St

17 (a)

Burial

(b) Date thereof Oct 25-1943

(c) Cemetery or crematory

St Marys Cem

18 (a) Funeral director

Pratt & B. M. Walters

(b) Address

Pratt & Stricker St

19 (a)

Signature

Huntington Williams, M.D.

(b)

Signature

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1943 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1943 to Oct. 21 1943, and that I last saw him alive on Oct. 21 1943.

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Morris Dehner

Address 54 S. Fulton Ave

Date signed 10-21-43

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

09356

BALTIMORE CITY HEALTH DEPARTMENT

G 09356

CERTIFICATE OF DEATH 467

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

a) Baltimore City, Maryland

b) Street address 1809 Regester St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1809 Regester St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROSE A. KOLBE

3 (b) If veteran, name war

3 (c) Social Security Account

No. Y19-10-0967

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Gustavus Kolbe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1894

8. AGE:

Years 48

Months 10

Days 16

If less than one day

hr.

min.

9. Birthplace Baltimore - Md.

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

At home

12. Name

John Mackesoy

13. Birthplace

Baltimore - Md.

14. Maiden Name

Rose O'Neill

15. Birthplace

16 (a) Informant Mr. Gustavus Kolbe

(b) Address 1809 Regester St.

17 (a)

Burial

(b) Date thereof Oct 26, 1942

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn Cem

Location

Baltimore

18 (a) Funeral director

Roth Co. B.M. Walters

(b) Address

Pretz, 1000 N. Hollinsworth St.

OCT 22 1942

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 21, 1942, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943, Oct 21, 1943, and that I last saw her alive on Oct 21, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of transport

23. Signature William P. Parnell

Address 801 N. Kensington St. Date signed Oct 21, 1942

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09357

BALTIMORE CITY HEALTH DEPARTMENT

G 09357

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 417 N. Belnord Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 417 N. Belnord Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SOPHIA-KUNCEWICZ

(ZOFIA-KANCIEWICZ)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Ignacy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years About 64 Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Dominic Stacewicz

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Eva Collins

(b) Address 417 N. Belnord Ave

17 (a) Burial (b) Date thereof 10-25-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd.

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

(c) City or town Baltimore, Md.

OCT 22 1943 (d) Date of death

(e) Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 19 43 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 19 43, to Oct 21 19 43, and that I last saw h. e. alive on Oct 20 19 43.

Immediate cause of death

Pneumonia
Hypostatic Pneumonia
Due to Senile changes

Duration

3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dr. D. L. Lipp

Address 432 1/2 Clifton Park Date signed 10/22/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09358
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Howard + Madison*

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7 7

(e) Length of stay in Baltimore (yrs., mos., or days)

7

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2706 Evergreen Av.*

(If rural, give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Esther C. Armstrong (Esther Cutter Armstrong)

3 (b) If veteran, name war

3 (c) Social Security Account

No. *--*

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

*widowed*6 (b) Name of husband or wife *Frederick A. Armstrong*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 20, 1883

8. AGE: Years

Months

Days

If less than one day

*60**6**1*

hr.

min.

9. Birthplace

New York

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name *George K. Cutter*13. Birthplace *N. Y.*14. Maiden Name *Esther Martense*15. Birthplace *N. Y.*16 (a) Informant *Mr. Carleton H. Peterman*(b) Address *2706 Evergreen Ave.*

17 (a) Removal

(b) Date thereof *10/22/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Greenwood Cem.*Location *Brooklyn, N. Y.*18 (a) Funeral director *WM. J. TICKNER & SONS*

(b) Address

Baltimore, Md.

19 (a)

*Oct 22 1943**Esther C. Armstrong, Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 21**1943 at 12:15 P*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 14* 1943 to *Oct 21* 1943and that I last saw her alive on *Oct. 21* 1943

Immediate cause of death

Hypertensive C.V.D.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy *Multiple emboli*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *G. Herman Williams*

M. D.

Address *Md. San Hosp.*

Date signed

Oct. 21, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 186

G 09359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09359

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

100 University Pkwy

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

100 W. University Pkwy

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Clarence Merryman Lucas

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widower

6 (b) Name of husband or wife

Emma Findlay Lucas

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr)

March 24, 1873

8. AGE:

Years

Months

Days

If less than one day

70

6

2027

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Public Utilities

FATHER

12. Name

Harry P. Lucas

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Annabelle Merryman

15. Birthplace

Baltimore

16 (a) Informant

H. Percy Lucas

(b) Address

Standard Oil Bldg.

17 (a)

Burial

(b) Date thereof

Oct 23 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Green Mount

Location

Baltimore Ind

18 (a) Funeral director

Henry H. Jenkins

(b) Address

Mc Culloch Orchard Co

(a)

22-1943

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 21st 1943, 11³⁰ A.M.21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1943 to Oct 21st 1943, and that I last saw him alive on Oct 21st 1943.

Immediate cause of death

Myocardial Infarction

Due to

Coronary Arteriosclerosis (arteriosclerosis)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J.H. Cabot

Address

Date signed

M. D.

Oct 22/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09360

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1611 Baker St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days none

(e) Length of stay in Baltimore (yrs., mos., or days) many life

3 (a) FULL NAME

FATHER FRANCIS PATRICK RYAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept 2, 1891

8. AGE: Years Months Days If less than one day
52 3 19 hr. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

Roman Catholic Priest

11. Industry or business

MOTHER | FATHER

12. Name

Francis Patrick Ryan
Mr

13. Birthplace

14. Maiden Name

Mary Carroll
Mr

15. Birthplace

16 (a) Informant

Fr. Fidler

(b) Address

611 Baker St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/24/43
(month) (day) (Year)

(c) Cemetery or crematory

Location

Catharine
St. Ignace Rm

18 (a) Funeral director

(b) Address

1318 Light St.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1611 Baker St

(e) Citizen of foreign country

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1943 at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Read on Arrival 1943

and that I last saw him alive on 19
Immediate cause of death Heart Failure

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

at M

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Henry F. Zangara

Address

Murray Hospital

Date signed Oct 24

Approved by Howard J. McQuade

1943.

G 09261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore, Maryland

(c) Hospital or institution:
South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 739 Kensington Ave. (If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (If rural give location)

(f) If yes, name country (Yes or No)

3 (a) FULL NAME

RADIS, C. Brown

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. 234-24-1447

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John Shipley

6 (c) If above, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 13, 1906

8. AGE: Years 37 35 Months 4 Days 8 If less than one day

hr min

9. Birthplace

Martinsburg, W. Va.

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

16 (b) Address

17 (a) Burial, cremation, or removal

17 (b) Date thereof

17 (c) Cemetery or crematory

17 (d) Location

18 (a) Funeral director

18 (b) Address

18 (c) Address

18 (d) Address

18 (e) Address

18 (f) Address

18 (g) Address

18 (h) Address

18 (i) Address

18 (j) Address

18 (k) Address

18 (l) Address

18 (m) Address

18 (n) Address

18 (o) Address

18 (p) Address

18 (q) Address

18 (r) Address

18 (s) Address

18 (t) Address

18 (u) Address

18 (v) Address

18 (w) Address

18 (x) Address

18 (y) Address

18 (z) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1943, at 9:45 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury October 21, 1943

(b) Where did injury occur? Light & Conway Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No

(d) Means of injury Pedestrian struck by auto.

23. Signature H. L. Wallerstein M.D.

Date signed 10-21-43 Medical Examiner.

G 09362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G 09362

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *found 7 735 N. Fulton Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *16*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Ethel L. Beere

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

James J.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 3 - 1890

8. AGE: Years

72

Months

11

Days

10

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Homework

11. Industry or business

FATHER

12. Name

John. Ogle

13. Birthplace

Balto. Md.

MOTHER

14. Maiden Name

Ethelander Harrison

15. Birthplace

Balto. Md.

16 (a) Informant

Mrs. Marie Rice

(b) Address

224 Hopkins Rd.

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct. 25 - 43

(month) (day) (year)

(c) Cemetery or crematory

New Bath

Location

Old Frederick Rd.

18 (a) Funeral director

John A. McNamee

(b) Address

4401 Crescent. Ave

19 Date of death

Oct. 22, 1943

20 Registered

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Baltimore Rogers Forge

(If outside city or town limits, give RURAL and county)

(d) Street No.

224 Hopkins Rd.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct. 21 -*19 *43*, at

M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 *39* to *Oct. 21* 19 *43*and that I last saw her alive on *Apr* 19 *43*.

Immediate cause of death

Chr. Myocardial Degenerat

Due to

Duration

5 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Norman U. Todd

M. D.

Address

735 N. Fulton Ave

Date signed

10/22/43

Every item of information should be carefully supplied. The object age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09363

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09363
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1017 N. Carrollton Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *16*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Mary Elizabeth Hill

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

David Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 16, 1880

8. AGE:

63

Years

Months

8

Days

4

If less than one day

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Cornish

13. Birthplace

Md.

MOTHER

14. Maiden Name

Georganna Budd.

15. Birthplace

Balto Md

16 (a) Informant

(b) Address

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 23, 1943

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

18 (a) Funeral director

Mrs Kate R. Williams

(b) Address

322 N. Schreder St

Oct 22 1943

Hamington Williams, Mayor

VS 186

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

1017 N. Carrollton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 20 1943 7:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from *Oct 10 1943* to *Oct 20 1943*, and that I last saw him alive on *Oct 20 1943*.

Immediate cause of death

Coronary Artery Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

J. B. Williams
831 N. Carrollton Ave

Date signed *10/22/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The complete age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09364

Registered No. 3698

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1325 Carey St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

3 (a) FULL NAME Mary Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Wm. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1893

8. AGE: Years Months Days

If less than one day

60 5- 23-

hr. min.

9. Birthplace Gloucester Co. Va

(Town, county, and state)

10. Usual Occupation

Home work

11. Industry or business

own home

FATHER
MOTHER

12. Name Spencer Reed

13. Birthplace

Va

14. Maiden Name

Bassett ?

15. Birthplace

Va

16 (a) Informant

Herbert Courtney

(b) Address

1325 Carey St.

17 (a) Burial

(b) Date thereof Oct. 23-43

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Arbutus Memorial

Location

18 (a) Funeral director

Mrs. Katie R. Williams

(b) Address

322 N. Schroeder St.

22 (a) 1943

by registration

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1325 Carey St.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-20 1943, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943, to Oct-24 1943, and that I last saw her alive on Oct 19, 1943.

Immediate cause of death

Carcinoma uteri

Due to

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

Specify type of place)

(e) Means of injury

23. Signature Francis T. Saunders

M. D.

Address 1029 N. Stricker

Date signed 10-21-43

09365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09365
Registered No.

37425

ya

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 4940 Eastern Avenue
 (c) Hospital or institution:
 BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs. 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Balto.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 401 Perry Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Norman Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
Colored6 (a) Single, married, widowed, or divorced
Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1886

8. AGE: Years 56 Months 9 Days 17
 If less than one day
 hr min

9. Birthplace Washington D. C.
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Carter (d)

13. Birthplace Va.

14. Maiden Name Fannie ?

15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (b) Date thereof
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 22 1943

18 (a) Funeral director

Commissioner of Health

(b) Address
 OCT 22 1943 Huntington Williams, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1943 at 3:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 10/13 1943 and that I last saw him alive on 10/13 1943.

Immediate cause of death

C.N.S. Les; hyper-
 pyrexia: etiol.

Due to

Due to

Other Conditions Drinker of
 alcohol etiology

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature E. L. Seymour

Address B C H

Date signed 10/19

Duration

13 yrs.

3 M.

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09366

MJ-57297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09366
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs., 3 mos., 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

3 (a) FULL NAME

Edward Berg

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or
divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-1880

8. AGE: Years Months Days If less than one day
62 10 11 hr min.

9. Birthplace Sweden

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Orderly

12. Name Pekvirik Berg (D)

13. Birthplace Sweden

14. Maiden Name Marie Lindquist (D)

15. Birthplace Sweden

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 22 1943

18 (a) Funeral director Commissioner of Health

19 OCT 22 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1417 W. Fayette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1943 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 10/15 1943
and that I last saw him alive on 10/15 1943.

Immediate cause of death

embolus on pul. embolus

Due to Hypertensive C.V. disease; thrombophlebitis.
Due to

Other Conditions Old hemiplegia;
thrombophlebitis, left leg;

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature E. L. Serquian

Address 10 C H

Date signed 10/19

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09367
JL - 78177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 09367
Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Babbitt

3 (b) If veteran, name war 3 (c) Social Security Account No. Yes

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1915

8. AGE: Years 28 Months 6 Days 16 If less than one day hr min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Unemployed

12. Name Henry Babbitt

13. Birthplace N. C.

14. Maiden Name Mary Slays

15. Birthplace N. C.

16 (a) Informant B. C. H. Records

(b) Address

17 (a) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 22 1943

18 (a) Funeral director Commissioner of Health

(b) Address

OCT 22 1943 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1947 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1942, to 10-17 1947, and that I last saw him alive on 10-17 1947.

Immediate cause of death Pulmonary TB

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mattina M.D.

Address RCH

Date signed 10/21/47

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH *94a*

✓ G 09368
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *Calvert & Lexington Sts.*
(c) Hospital or institution: *May Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *67 yrs.*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md.* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2729 Maryland Ave.*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country *I*

3 (a) FULL NAME *Charles A. Miles*
3 (b) If veteran, name war *-*
3 (c) Social Security Account No. *-*

4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced *Widowed*
6 (b) Name of husband or wife *Mrs. C. H. Miles*
6 (c) If alive, give age *-* years

7. Birth date of deceased (mo., day, yr.) *Oct 21, 1876*
8. AGE: Years *67* Months *1* Days *1* If less than one day hr. *-* min. *-*

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation *Owner - Hardware*
11. Industry or business *Company*

FATHER 12. Name *James A. Miles*
13. Birthplace *Maryland*
MOTHER 14. Maiden Name *Agnes Jane*
15. Birthplace *Maryland*

16 (a) Informant *Richard Kohn*
(b) Address *May Hospital*

17 (a) *Burial* (b) Date thereof *10-25-1943*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *Cathedral Cemetery*
Location *-*

18 (a) Funeral director *May M. Weddfield*
(b) Address *571 E. 12th St.*

OCT 22 1943 *Washington Williams, M.D.*
VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 22, 1943* at *7:05 AM*
21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 16, 1943* to *Oct 23, 1943*, and that I last saw him alive on *Oct 23, 1943*.

Immediate cause of death *Coronary Thrombosis*
Due to *Coronary Thrombosis*
Due to *-*
Other Conditions *-*

(Include pregnancy within 3 months of death)
Date of operation *None*
Major findings of operation: *-*
of autopsy: *-*

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence *-* at *M*
(c) Where did injury occur? *-* (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? *-* (Specify *at* of place) While at work? *-*
(e) Means of injury *-*

23. Signature *Edmund Wayne Lee*
Address *May Hospital* Date signed *10/23/43*

Duration
Coronary Thrombosis
7 days
finds of death
PHYSICIAN
Underline the cause to which death should be charged statistically.

G 09369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09369
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2452 Greenmount Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(d) Street No.

2452 Greenmount Ave

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

Virginia Trulish Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

John Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882-1862

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

George P. Trulish

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Annie Kumpf

15. Birthplace

Baltimore

16 (a) Informant

Mrs. Grafton, Sister

(b) Address

20 E

17 (a)

Burial, cremation, or removal

Date thereof 10-25-1943

(c) Cemetery or crematory

Baltimore

Location

18 (a) Funeral director

May M. Wedgeford

(b) Address

101 E 22nd St.

(File rec'd by registrar)

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1943, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 1, 1941, to present time and that I last saw her alive on JUNE 1943.

Immediate cause of death Rupture of oesophageal varix

Duration Sudden

Due to

Due to

Other Conditions

Myocardial degeneration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. Willis Guyton

Address

3963 Greenmount Ave

Date signed 10/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09370
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2019 Walbrook Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

7

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Bremker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

69

-

26

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 22 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2019 Walbrook Ave.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 20 1943

at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 12 1943 to Oct 20 1943 and that I last saw her alive on Oct 20 1943.

Immediate cause of death

Cardiac -

insufficiency -

Due to Coronary -

Arteriosclerosis -

Due to

Other Conditions

Arterio-sclerotic

+ Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Marlin H. Schorb

Address: 764 Fulton Ave. Baltimore, Md.

MARLIN SCHORB

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G 09371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09371
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 5505 Ready Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Ready Avenue
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME

Marie Victorine Schanberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John G. Schanberger
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) --- 1869

8. AGE: Years Months Days If less than one day
About 74 --- --- -- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ---

FATHER 12. Name Patrick Gahan

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Powell

15. Birthplace England

16 (a) Informant Mrs. Marie V. Renehan

(b) Address Hartford, Connecticut

17 (a) Burial (b) Date thereof 10/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director L. W. Mears and Son
895 N. Calvert Street

OCT 22 1943

(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 20 1943 8:27 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1943 - Oct 20 1943, and that I last saw him alive on Oct 19 1943.

Immediate cause of death Duration

Bronchial Pneumonia 7 days

Due to Congestive heart failure 5 weeks

M. Trauma/Stroke year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of injury)

(e) Means of injury

23. Signature

Address

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09372 436569		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		G 09372 Registered No.	
1. PLACE OF DEATH: (a) Baltimore City, Maryland		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Md</u> (b) County _____ (c) City or town <u>BALTIMORE</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>114 S BROADWAY</u> (If rural give location) (e) Citizen of foreign country? _____ (Yes or No) If yes, name country _____			
3 (a) FULL NAME <u>Steve Vinick</u>		3 (b) If veteran, name war _____ 3 (c) Social Security Account No. _____			
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>MARRIED</u>			
6 (b) Name of husband or wife <u>Katie</u>		6 (c) If alive, give age <u>40</u> years			
7. Birth date of deceased (mo., day, yr.) <u>9 - 2 - 98</u>		8. AGE: Years <u>45</u> Months <u>1</u> Days _____ If less than one day hr. _____ min. _____			
9. Birthplace <u>Poland</u> (Town, county, and state)		10. Usual Occupation <u>Laborer</u>			
11. Industry or business _____		12. Name <u>Stanley Vinnick</u>			
13. Birthplace <u>Poland</u>		14. Maiden Name <u>Bergan Tickala</u>			
15. Birthplace <u>Poland</u>		16 (a) Informant <u>Records</u>			
16 (b) Address <u>JOHNS HOPKINS HOSPITAL</u>		17 (a) <u>BURIAL</u> (b) Date thereof <u>10/23/43</u> (Burial, cremation, or removal) (month) (day) (year)			
17 (c) Cemetery or crematory <u>Holy Trinity</u> Location <u>ANNE ARUNDEL COUNTY</u>		18 (a) Funeral director <u>M. J. Sadowski & Son</u>			
18 (b) Address <u>1808 Eastern Ave.</u>		19 (a) <u>OCT 22 1943</u> (b) _____ (Registrar) (Signature) <u>Huntington Williams</u>			
20. DATE OF DEATH <u>Oct 20</u> 19 <u>43</u> <u>11:05 P</u>		21. I certify that death occurred on the date above stated; that I attended deceased from <u>JUNE 19 1943</u> to <u>OCT 20 1943</u> , and that I last saw him alive on <u>OCT 20 1943</u> . Immediate cause of death <u>Respiratory failure</u> Due to <u>Hypertensive cardiac vascular renal disease</u> Due to _____ Other Conditions <u>Ischemic atherosclerosis</u> (Include pregnancy within 3 months of death) Date of operation _____ Major findings of operation: _____ of autopsy: _____			
22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide _____ (b) Date of occurrence _____ at _____ M (c) Where did injury occur? _____ (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place) (e) Means of injury _____		23. Signature <u>J. H. H.</u> Address _____ Date signed <u>10-21-43</u>			

09373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09373

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 10. S. Patterson Park

(c) Hospital or institution:

old age home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Rozalia Sasiadek

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband

Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1887

8. AGE: Years

84

Months

Days

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Nurse

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden Name

unknown

15. Birthplace

unknown

16 (a) Informant

Victoria Bowe

(b) Address

317 S. Wolfe St

17 (a)

Burial

(b) Date thereof

10-20-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

Baltimore Md

18 (a) Funeral director

George A. Weber

(b) Address

701 S. Ann St

OCT 22 1943

(Date rec'd by registrar)

(b) Hunterton Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

10. S. Patterson Park

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 - 1943 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 18 1943 to OCT. 22 1943 and that I last saw her alive on OCT. 22 1943.

Immediate cause of death ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE

Duration ??

Due to

Due to

Other Conditions

GENERALIZED VASCULAR SCLEROSIS

??

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph F. Hanga

Address

209 B. State St

Date signed

10/22/43

G 09374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09374

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 E Baltimore St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1200 E Baltimore St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FERDINAND

COLLUCCI

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

1893

8. AGE: Years Months Days If less than one day

50

hr. min.

9. Birthplace

Naples, Italy
(Town, county, and state)

10. Usual Occupation

Cook

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Vincent Tenace

(b) Address

100 S. Bond Street

17 (a)

Burial

(b) Date thereof

10/23/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

St. Raphael

Location

Baltimore

18 (a) Funeral director

Joseph Farace Inc.

(b) Address

2013 Greenmount Ave

19 (a)

(b) Date of registration

Huntington Williams, MD

VB 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1943, at 10:45 PM

21. I certify that I took charge of the remains described above, held an
autopsy, inspection or inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased cameto death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Tuberculosis, pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature J. Z. Wollenshagen MD.

Medical Examiner.

Date signed 10-20-43

09375 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 937

PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 NORTH MILTON AVE

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2 FULL NAME ISAAC HESS

Registered No.
(If death occurred in
a hospital or institution,
give its NAME instead
of street and number.)
If U. S. Veteran
specify WAR. No

(a) Residence: No. 21 N. MILTON AVE

St.,

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX MALE 4. Color or Race WHITE 5. Single, Married, Widowed, or WIDOWER

6a. If married, widowed, or divorced
HUSBAND of CARRIE HESS
(or) WIFE of

6. DATE OF BIRTH (month, day, year) JUNE 22-1872

7. AGE Years Months Days If LESS than
1 day, hrs. or min.
71 48. Trade, profession, or particular
kind of work done, as spinner, sawyer, bookkeeper, etc. RETIRED INSURANCE AGT9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc. INSURANCE10. Date deceased last worked at
this occupation (month and
year) 11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country) BALTO MD.

13. NAME LOUIS HESS

14. BIRTHPLACE (city or town)
(State or country) GERMANY

15. MAIDEN NAME LISETTE LEHMAN

16. BIRTHPLACE (city or town)
(State or country) GERMANY17. INFORMANT MRS CHARLES BALL
(Address) 21 N. MILTON AVE

18. BURIAL, CREMATION, OR REMOVAL

BURIAL

OCT 24th-43

19. UNDERTAKER J. AHRENS CO

(Address) 2432 REISTON RD

OCT 22 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 10/22/43

22. I HEREBY CERTIFY, That I attended deceased from
Aug 8th 1943 to 10/21/43I last saw him alive on 10/21/43 Death is said
to have occurred on the date stated above, at 12:00 A.The principal cause of death and related causes of
importance were as follows:Cardio Vascular
disease

Other contributory causes of importance:

Extensive atherosclerosis

Was an operation performed? no Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the fol-
lowing:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public
place

Manner of injury

Nature of injury

Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H. J. Lankford

M. D.

(Address) 100 N. Milton Ave

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09376

09376

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(d) Street No. 225 E. University Pkwy

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Stella E Seal

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced Married

6 (b) Name of husband or wife

William Reed Seal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

Dec 24th 1880

8. AGE: Years Months Days If less than one day

62 9 28 27 hr. min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

At home

12. Name

Louis Matthaei

13. Birthplace

Charles Town W. Va.

14. Maiden Name

Elizabeth Cathardt

15. Birthplace

Germany

16 (a) Informant

William Reed Seal

(b) Address

225 E. University Pkwy

17 (a) Cause of death

(b) Date thereof

(c) Burial, cremation, or disposal

(d) Cemetery or crematorium

(e) Location

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

(m) Address

(n) Address

(o) Address

(p) Address

(q) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21st 1943 at M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan. 1937 to Oct 8 1943

and that I last saw her alive on Oct 8 1943.

Immediate cause of death

Coronary Thrombosis

Due to Chronic Hypertensive

Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

10/21/43

OCT 23 1943

09377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09377
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. at Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1822 W. Lafayette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George Thomas Mitchell

3 (b) If veteran, name war

I W

3 (c) Social Security Account

No. DATE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed or

discarded Married

6 (b) Name of husband or wife Mary Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 - 1867

8. AGE: Years Months Days If less than one day

76 9 12 hr. min.

9. Birthplace Prince George Co. Md.

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Carpenter

12. Name George T. Mitchell

13. Birthplace Md.

14. Maiden Name Matilda A. Brooks

15. Birthplace Md.

16 (a) Informant Mrs Mary T. Mitchell

(b) Address 1822 W. Lafayette Ave

17 (a) Burial (b) Date thereof 10/25/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 S. Park St

Huntington Williams, M.D.

19 (a) Date of death 23-1943

(b) Registrar

20. DATE OF DEATH Oct 21 1943 at M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Jan 1943 to Oct 1943.

and that I last saw him alive on Oct 1 1943.

Immediate cause of death Coronary Thrombosis

Due to Arterio Sclerotic Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman R. Korman

Address 1101 N. Fulton Ave Date signed 10/23/43.

M. D.

Duration 3 mos.

5 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The

09378

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09378

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Bon Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(d) Street No. 1441 Riverside Ave

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

(b) If veteran, name war

(c) Social Security Account

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1865

8. AGE: Years Months Days

78

0

27

hr.

min.

9. Birthplace

Balto. Md

10. Usual Occupation

11. Industry or business

12. Name Michael McDonough

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Louise Link

(b) Address 7118 Old Harbor Rd

17 (a) Burial (b) Date thereof Oct. 25, 1943

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Walling & Cook, Inc.

(b) Address 1217 St. Paul St.

OCT 23 1943 (b) Huntington Williams, M.D. Registrar

For B. R. L. Graham, by Thomas J. Chadden, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1943 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1943 to 10/22 1943

and that I last saw her alive on 10/22 1943.

Immediate cause of death Hypertensive

pneumonia

Due to Arteriosclerosis

Cardio-Vascular Disease

Due to

Other conditions Fracture neck

of rt. humerus. (9/18/43)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following: 24/2

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 9/17/43

(c) Where did injury occur? 1441 Riverside Ave

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no

(e) Means of injury slipped and fell

23. Signature

Address Bon Secours Hosp.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 W. Franklin St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME Mary Thompson

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F 5. Color or race C 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1874

8. AGE: Years 69 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Henry Howard

13. Birthplace Md.

14. Maiden Name Sophia ?

15. Birthplace Md

16 (a) Informant Mary M. Trusty (Sister-in-law)
(b) Address 1006 W. Franklin St.

17 (a) Burial (b) Date thereof 10/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton Ave

OCT 23 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/43 19 at 5:15 M

21. I certify that death occurred on the date above stated that I attended deceased from Oct 1 1942 to Oct 10 1942 and that I last saw him alive on Oct 10 1942.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles G. Cooper

Address 84 Park St Date signed 10/23/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09380

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2, 2, 4(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1620 Millman St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Eugene Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C.

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18th 18848. AGE: Years Months Days If less than one day
59 4 1 hr. min.9. Birthplace Balto. Md.
(Town, county, and state)10. Usual Occupation Labourer

11. Industry or business

12. Name Manuel Stewart13. Birthplace md.14. Maiden Name Emma Steiner15. Birthplace md.16 (a) Informant Bernice Stewart(b) Address 1620 Millman St17 (a) Burial (b) Date thereof Oct 23-1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt calvaryLocation C.A. Co. Md.18 (a) Funeral director Bryant, Mamie Wright(b) Address 721 Alsquith St(c) 23 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19th 1943 at M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.Date signed Oct. 19 1943 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09381
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address (?)

(c) Hospital or institution:

Pronounced dead @ Franklin Sq. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

3 (a) FULL NAME Edith M. Bayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

James O. Bayton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 13 - 1895

8. AGE: Years

48

Months

7

Days

7

If less than one day

hr. min.

9. Birthplace

Brown (Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

Mason (Booker)

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Clara Lewis

(b) Address

1601. Mosher

17 (a) Burial, cremation, or removal

17 (b) Date thereof

Oct 35 45

(c) Cemetery or crematory

Location

18 (a) Funeral director

18 (b) Address

19 (a) OCT 23 1945

(b) Date of registrar

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1601. Mosher

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/43 19 at 4:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Thrombosis?

Due to D. O. A - brought to

Due to Franklin Square Hosp.

- Released by coroner

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature Joseph B. Lawkaitis

Address Franklin Square Hosp

Date signed

Approved for Dr. Wollenweber: Robert Lee Graham M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 00382

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE, Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from

and that I last saw her alive on

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

(City or town) (County) (State)

(Specify type of place)

While at work?

Date signed /

Address

1445 N. Gay St

10/23/43

Huntington Hill, Md.

10/23/43

10/23/43

10/23/43

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10/23/43

10/23/43

10/23/43

10/23/43

G 09383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09383

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Melkins and Caton Ave.*

(c) Hospital or institution:

St. Agnes Hospital 9-9(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 min*(e) Length of stay in Baltimore (yrs., mos., or days) *10 min*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1220 E. Federal St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

*Female White**Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *10-22-43*

8. AGE: Years Months Days If less than one day

hr. *10* min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *Bernard*

13. Birthplace

MOTHER

14. Maiden Name *Annmarie Tricke*15. Birthplace *Maryland*

16 (a) Informant

(b) Address

17 (a) *Burial*(b) Date thereof *10/23/43*
(month) (day) (year)

(c) Cemetery or crematory

Location *Holy Redeemer*
Belair Road

18 (a) Funeral director

(b) Address

19 (a)

OCT 28 1943

Registrar

VB 144

MEDICAL CERTIFICATION

20. DATE OF DEATH

*10/22 1943 at 6:20 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *10/22 1943* to *10/22/43* 19and that I last saw her alive on *10/22/43*

Immediate cause of death

Still Birth
Complication of pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *W. F. Bryant*Address *St Agnes Hosp* Date signed *10/23/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G-09384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG-09384
Registration No. 108

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 110

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1255 N. Broadway

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Katherine Price KATHERINE PRICE

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Charles A. Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1874

8. AGE: Years Months Days If less than one day
38 10 24 hr. min.9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name August Pfeiffer

13. Birthplace Baltimore, Maryland

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Lester Carpenter

(b) Address 3114 Northway Drive

17 (a) Burial (b) Date thereof 10/23/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 649 E. North Ave.

10 OCT 23 1943
(Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1943, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1943, to 10-21 1943, and that I last saw him alive on 10-21 1943.

Immediate cause of death Lobar Pneumonia

Duration

app 2 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathan E. Blodi

Address St Josephs Hosp. Date signed 10-21-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09385

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1709 E. Oliver St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

PHILIP ADOLPH SONDERMAN

3 (b) If veteran, name war

World War # 1

3 (c) Social Security Account

No. 218-03-4707

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Mary Creamer
Sonderman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1887
8. AGE: Years 58 Months 9 Days 20
If less than one day hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Parri-Mutuel Co.

12. Name Philip Adolph Sonderman

13. Birthplace Germany

14. Maiden Name Elizabeth Dahnke

15. Birthplace Germany

16 (a) Informant Mr. Wm. Henry Sonderman

(b) Address 1709 E. Oliver St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10/23/43
(month) (day) (year)(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1849 E. North Ave.

19 (a)

(Date rec'd by registrar)

OCT 23 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1709 E. Oliver St.

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1943 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1943 to Oct. 21 1943
and that I last saw him alive on Oct. 20 1943

Immediate cause of death

Cirrhosis of liver
Due to Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address

John V. Szejnrich
1802 Eastern
Date signed 10-21-43

Duration

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09386

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Steward

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. Dunlaggin Farms(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 19288. AGE: Years Months Days If less than one day
15 6 24 hr. min.9. Birthplace Sykesville, Ind
(Town, county, and state)10. Usual Occupation Farm work

11. Industry or business

12. Name William N. Smith13. Birthplace Ind14. Maiden Name Geneva Payne15. Birthplace Va.16 (a) Informant Wm. N. Smith(b) Address Elliot City, Ind17 (a) Burial (b) Date thereof 10-25-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. John's
Location Elliot City, Ind18 (a) Funeral director J. H. Kington(b) Address Elliot City, Ind19 OCT 23 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1943, at M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

skullFracture of

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury October 22, 1943 3:05 P.(b) Where did injury occur? Dunlaggin Farms(c) Did injury occur at home, on farm, in usual place, in public place? on farm While at work? yes(d) Means of injury Wagon rolled over him23. Signature Robert Lee Graham M.D.Signed Oct. 22 1943

09387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09387
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 1649 Darley Ave.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1649 Darley Ave.
(If rural, give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna L. Hopkamp

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced married6 (b) Name of husband or wife John H. Hopkamp
6 (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Feb. 28, 18798. AGE: Years 64 Months 7 Days 23 If less than one day
hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Housewife11. Industry or business at home12. Name Louis Fisher13. Birthplace unknown14. Maiden Name Rosenthal15. Birthplace unknown16 (a) Informant John H. Hopkamp(b) Address 1649 Darley Ave.17 (a) Burial (b) Date thereof 10/25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood Cem.
Location18 (a) Funeral director G. Vernon Lemmon(b) Address 4611 Park Heights Ave.19 (a) 23 1943 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 194321. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1943 to Oct. 21, 1943, and that I last saw him alive on Oct. 20, 1943.Immediate cause of death Myocardial C. V. R. disease Duration 2 years

Due to

Due to

Other Conditions Coronary Thrombosis 1 year
Diastolic Insult
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
- (e) Means of injury

23. Signature Arthur P. SchenckAddress 2939 W. Belknap Date signed 10/21/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09388

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Green T. Lombard St.*

(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *19*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1819 Doran St.*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *December 7-1934*

8. AGE: Years Months Days If less than one day
8 10 18 hr. min.

9. Birthplace *Baltimore Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business *School*

12. Name *Harry Russell*

13. Birthplace *Balto. Md.*

14. Maiden Name *Elizabeth P. Robinson*

15. Birthplace *Balto. Co. Md.*

16 (a) Informant *Harry Russell*

(b) Address *1819 Doran St.*

17 (a) *Burial* (b) Date thereof *Oct. 26-1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Int. Olivet*

Location *Baltimore*

18 (a) Funeral director *George L. Schwalb*

(b) Address *2101 Chaderick Ave*

19 (a) (b) *Huntington Williams*

Oct 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/22 1943* at *2:30 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/19 1943* to *10/22 1943*, and that I last saw h&r alive on *10/22 1943*.

Immediate cause of death

Ht. failure + pulmonary edema

Due to *Peritonitis*

Due to *Acute suppurative appendicitis*

Other Conditions *Generalized lymphadenitis*

(Include pregnancy within 3 months of death)

Date of operation *10/19/43*

Major findings of operations:

Acute suppurative app + peritonitis of autopsy. Peritonitis, pulmonary edema

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Josephine E. Penhag*

Address *Univ. Hosp* Date signed *10/22*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 093889 26-84380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09389
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Leonard McNew

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1867

8. AGE: Years 76 Months 3 Days 3 If less than one day
hr min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

Unable to Work

11. Industry or business

12. Name Henry McNew (D)

13. Birthplace Washington, DC

14. Maiden Name Isabelle Haslups (D)

15. Birthplace Washington, DC

16 (a) Informant BALTIMORE CITY HOSPITAL

(b) Address (RECORDS)

17 (a) BURIAL (b) Date thereof OCT 2 5-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MOUNT CARMEL
Location O'DONNELL ST.

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST.

OCT 23 1943
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. No Home
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1943 5:45 PM

21. I certify that death occurred on the date above stated; that I attended
deceased from 10-13 1943 to 10-21 1943,
and that I last saw him alive on 10-21 1943.

Immediate cause of death

Carcinoma of Face
Due to Bronchopneumonia
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Donald A. Smith
Address Baltimore Hosp. Date signed 10-22-43

Duration

10 yrs
5 days

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

09390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09390
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1604 McHenry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days):

3 (a) FULL NAME

Annie Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Widest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1876

8. AGE:

Years

Months

Days

If less than one day

67

hr.

min.

9. Birthplace

St Mary County

(Town, county, and state)

10. Usual Occupation

House Work

11. Industry or business

FATHER
MOTHER

12. Name

John Greenfield

13. Birthplace

St Mary County

14. Maiden Name

Thomason

15. Birthplace

St Mary County

16 (a) Informant

Thomas Greenfield

(b) Address

1604 McHenry St

17 (a)

Burial

(b) Date thereof

Oct 25-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cem

Location

Old Frederick Rd

18 (a) Funeral director

Joseph Casinskas Inc

(b) Address

624 Washington Blvd

OCT 23 1943

Huntington Williams

VS 116

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1604 McHenry St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-1943 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9 1942 to 10/21 1943 and that I last saw her alive on 10/21 1943.

Immediate cause of death

Acute Cardiac Failure

Duration

1 day

Due to

Hypertensive Cardiovascular

Due to

Disease

syn

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph J. Law

Address

624 Washington Blvd

Date signed

10/21/43

G 09391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09391

Registered No.

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street *Monument & Rutland*

(c) Hospital or institution:

Sinai Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 1/2 mos.*(e) Length of stay in Baltimore (yrs., mos., or days) *Lifetime*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Temple Garden Gdb.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)If yes, name country *Madison Ave + bldg*

3 (a) FULL NAME

Rena G. Kahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Jerome W. Kahn*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb. 4, 1893*

8. AGE:

Years

Months

Days

If less than one day

*50**8**18*

hr.

min.

9. Birthplace

Balt. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Emanuel Katz

13. Birthplace

Germany

MOTHER

14. Maiden Name

Roddie Fleishman

15. Birthplace

Balt. Md.

16 (a) Informant

Mrs. Jerome W. Kahn

(b) Address

*Temple Garden Gdb.*17 (a) *Burial*(b) Date thereof *10/24/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

*Hebrew Friendship*Location *Balt. Md.*

18 (a) Funeral director

David Smarshin & Son

(b) Address

1902 Eastern Place

19 (a)

(b)

*OCT 28 1943**Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 22, 1943, at 5:30 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 3, 1943, to Oct 22, 1943.* and that I last saw her alive on *Oct. 21, 1943.*

Immediate cause of death

Respiratory failure

Due to

Melanosis

Due to

Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Henry Musumeci*Address *Sinai Hosp* Date signed *10/24/43*

Duration

80 Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09392

BALTIMORE CITY HEALTH DEPARTMENT

G 09392

CERTIFICATE OF DEATH 5413

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address:

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 23 1943

Huntington Williams, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT 22 1943 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1939 to Oct 22 1943 and that I last saw her alive on Oct 21 1943

Immediate cause of death

Tumor of brain

Duration?

2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Jack J. Singer

Address 506 E North Ave

Date signed OCT 22 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09393

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 30 1943 and that I last saw him alive on 10-20-1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(g) Means of injury

Signature

Address

Date signed

M. D.

Previous entries, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-3025
09394
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
G 09394
Registered No. 46F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: **va** (b) County
(c) City or town: **Middlestown**
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Charles R. Curtis**
3 (b) If veteran, name war No. 3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **white** 6 (a) Single, married, widowed, or divorced **Married**
6 (b) Name of husband or wife **Elizabeth** 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) **10-25-88**
8. AGE: Years **54** Months **11** Days **27** If less than one day hr. min.
9. Birthplace **Md. Balto.**
(Town, county, and state)
10. Usual Occupation **Minister**
11. Industry or business

12. Name **George W. Curtis**
13. Birthplace **Md.**
14. Maiden Name **Sarah Thompson**
15. Birthplace **Md.**

16 (a) Informant **Records**
(b) Address **JOHNS HOPKINS HOSPITAL**

17 (a) **Burial** (b) Date thereof **10/25/43**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory **Woodlawn Cem.**
Location **Woodlawn, Md.**

18 (a) Funeral director **WM. J. TICKNER & SONS**
(b) Address **Balto., Md.**
OCT 23 1943 **Huntington Williams, M.D.**

20. DATE OF DEATH **Oct 22 1943 9:15 AM**
21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 17 1943** to **Oct 22 1943** and that I last saw him alive on **Oct 22 1943**
Immediate cause of death **Carcinoma of liver**
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation **10-21-43**
Major findings of operation **Carcinoma of liver**
of autopsy **Primary carcinoma of liver**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature **Dr. George Bunch, Jr.**
Address **Johns Hopkins Hosp.** Date signed **10/23/43**

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09395

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2730 The Alameda
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY CATHERINE SHANEY

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1852

8. AGE: Years 91 Months 2 Days 15 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Andrew Linhard

13. Birthplace Bavaria

14. Maiden Name Selma Feldhaus

15. Birthplace Germany

16 (a) Informant Mrs. Grace L. Reid

(b) Address 2730 The Alameda

17 (a) Burial (b) Date thereof 10/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 OCT 23 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1943, 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11:15 1943 to Oct 22 1943, and that I last saw him alive on Oct 22 1943

Immediate cause of death

Coronary atherosclerosis
Due to atherosclerosis of coronary arteries

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. [Signature]
Address 5136 [Address] Date signed 10/23/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09396
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

3 (a) FULL NAME John F. Rott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Year: 7 Months: 11 Days: 30 If less than one day hr. min.

9. Birthplace Petersburg, Va.
(town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business St. Rita's

12. Name Frank J. Rott

13. Birthplace Petersburg, Va.

14. Maiden Name Anna Eyles

15. Birthplace Petersburg, Va.

16 (a) Informant Parents

(b) Address

17 (a) Burial (b) Date thereof Oct 25, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Laurel Hill Cem.

Location German Hill Road.

18 (a) Funeral director Charles E. Schumacher

(b) Address 2601 P. Madison St.

19 OCT 23 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Balto.

(c) City or town: Dundalk
(If outside city or town limits, write RURAL and give town)(d) Street No. 2706 N. Point Road
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-1943 at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiry thereon and from the evidence obtained
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 10-21-43 at 6 P.M.

(b) Where did injury occur? N. Point Rd. & Centwood Ave.

(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? No

(d) Means of injury Ran into an automobile

23. Signature Thomas J. Walshe M.D.

Date signed 10/24/43

Medical Examiner.

G 09397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09397

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Smith Balto. Sec. 1 Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) - 3

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph Kofsky

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

3/26/43

8. AGE: Years

Months

Days

If less than one day

76 25

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 28 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

Trailer Camp #6 - Fairfield

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-21-1943, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute Gastro-enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

Horton J. Waldeis

M.D.

Date signed

10-22-43

Medical Examiner.

G 09398

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09398

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2340 Fleet St.*

(c) Hospital or institution:

Home(d) Length of stay in hospital or inst. (yrs., mos., or days) *1*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2340 Fleet St.*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Margaret Myslak

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

*Frank*6 (c) If alive, give age *46* years

7. Birth date of deceased (mo., day, yr.)

1899

8. AGE:

Years

Months

Days

If less than one day

44

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Skalinshi

13. Birthplace

Poland

14. Maiden Name

Harczynska

15. Birthplace

Poland

16 (a) Informant

Frank Myslak

(b) Address

2340 Fleet St.

17 (a)

Burial

(b) Date thereof

10/25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

Dunfalk Ave

18 (a) Funeral director

John J. Puda

(b) Address

29 Hudson St.

OCT 23 1943

(b)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 22, 1943* at *10:40* A.M.21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 1, 1943* to *Oct 23, 1943*, and that I last saw him alive on *Oct 21, 1943*.

Immediate cause of death

Carcinoma of Lung & Breast

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? *While at work?*

(Specify type of place)

(e) Means of injury

23. Signature *Andrew Skalinshi*Address *2529 Eastern Ave.* Date signed *10/23/43*

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Provident Hosp*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *4-18*

(e) Length of stay in Baltimore (yrs., mos., or days) *30 yrs*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F*

5. Color or race *Col*

6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband or wife *Vernon*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *8-16-1903*

8. AGE: Years *38* Months *12* Days *5* If less than one day hr. min.

9. Birthplace *N. C.*
(Town, county, and state)

10. Usual Occupation *House wife*

11. Industry or business

12. Name *Willie ?*

13. Birthplace *N. C.*

14. Maiden Name *Sallie Watson*

15. Birthplace *N. C.*

16 (a) Informant *Vernon Butler*

(b) Address *719 W. Mulberry St*

17 (a) *Shipped* (b) Date thereof *10/23/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium *Center Grove Cem*
Location *Southern Pines, N. C.*

18 (a) Funeral director *William A. Jackson*

(b) Address *916 Perry Ave*

19 (a) *OCT 23 1943*
(Date rec'd by registrar)

Registrar

VS 184

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *719 W. Mulberry St*
(If rural give location)

(e) Citizen of foreign country? *✓* (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-21* 19*43* at *5:20 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9-18* 19*43* to *10-21* 19*43*, and that I last saw him alive on *10-21* 19*43*

Immediate cause of death

Intestinal Obstruction

Due to *Intestinal Obstruction*

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation *10-21-43*

Major findings of operations:
Intestinal obstruction of ascending colon

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *M. Williams*

Address *803 N. Fremont* M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09400
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34p.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Hanford
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Mary Glorias Hash

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1920

8. AGE: Years 23 Months 6+ Days 28 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

12. Name Eck L. Hash

13. Birthplace Virginia

14. Maiden Name Mary Beatrice McRinner

15. Birthplace Virginia

16 (a) Informant George Hash

(b) Address Pylesville, Md.

17 (a) Burial (b) Date thereof Oct 24, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Old Grove
Location Bel Air Md.

18 (a) Funeral director W. Howard Holt

(b) Address Franklin Ave. Pa.

(c) 24 1943 (Date rec'd by registrar) Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1943 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1943 to Oct. 23 1943, and that I last saw her alive on Oct. 23 1943.

Immediate cause of death Cardiac & Respiratory failure

Due to Pneumonia

Due to

Other Conditions Bronchiectasis
Lung abscess

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W. Montgomery Jr. M. D.

Address 332 E. University Mary Date signed 10/23/43

Duration

6 days

over

3 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09401
Registered No.

126

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *London & Green*

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 Days*

(e) Length of stay in Baltimore (yrs., mos., or days) *8 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County *aa*

(c) City or town *Annapolis*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *47 Dean*

(If rural, give location)

(e) Citizen of foreign country?

NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

William M. Bassford

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. *NO*

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

Ida R. Bassford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 29 - 1876

8. AGE:

Years

Months

Days

If less than one day

67

24

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

James Bassford

13. Birthplace

MD

14. Maiden Name

Mary Wells

15. Birthplace

MD

16 (a) Informant

Geo. Bassford

(b) Address

47 Dean St Annapolis, MD

17 (a) *Burial*

(b) Date thereof

Oct 26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lehrick Episcopal

Location

Greenville MD

18 (a) Funeral director

B. L. Hopping

(b) Address

Annapolis, MD

24 1943

(b) Registered by

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 23

19*43*

at *4 am*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *10/15 1942* to *10/23 1943*.

and that I last saw him alive on *10/23 1943*.

Immediate cause of death

Pulmonary Edema.

Due to *Arteriosclerotic heart disease*

Due to *Chronic cholelithiasis & cholecystitis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

10/15/42

Major findings of operations

Chronic cholelithiasis & cholecystitis

of autopsy *Pulmonary edema*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thomas L. Wilson

Address

University Hospital

Date signed

10/23/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09402

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2209 E. Baltimore St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2209 E. Baltimore St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W6 (a) Single, married, widowed, or
divorced.Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/14/1887

8. AGE:

56

Months

5

Days

8

If less than one day

hr.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation Fruit & Produce11. Industry or business OwnerFATHER
MOTHER12. Name Salvatore Catalano13. Birthplace Italy14. Maiden Name Anna Licastro15. Birthplace Italy16 (a) Informant Brother Sam Catalano(b) Address 2213 Prentiss Place17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct 26-43

(month) (day) (year)

(c) Cemetery or crematory Holy RedeemerLocation Balair Road18 (a) Funeral director Frank V. Pipitone(b) Address 2818 E. Balto St19 (a) 24 1943

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1943, at 5 PM21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ Accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Coronary
occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury _____

23. Signature

Robert C. Graham M.D.

Date signed

Oct. 23 1943

G 09403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09403
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **Wyman Park Drive and 31st St.**
- (c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) **5 mo 17 da**
- (e) Length of stay in Baltimore (yrs., mos., or days) **5 months**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Massachusetts**
- (b) City or town **Gloucester**
(If outside city or town limits, write RURAL and give town)
- (c) Street No. **424 Essex Ave**
(If rural give location)
- (d) Citizen of foreign country? (Yes or No)
- If yes, name country

3 (a) FULL NAME

ROBERT S. BRAY

3 (b) If veteran, name war

3 (c) Social Security Account
No. **None**

4. Sex **Male**
5. Color or race **White**
- 6 (a) Single, married, widowed, or divorced **Married**

- 6 (b) Name of husband or wife **Elizabeth Bowes**
- 6 (c) If alive, give age **23** years

7. Birth date of deceased (mo., day, yr.) **Dec. 20, 1913**

8. AGE: Years **29** Months **10** Days **3** If less than one day
hr. min.

9. Birthplace **GLOUCESTER, MASS.**
(Town, county, and state)

10. Usual Occupation **ENSIGN**

11. Industry or business

12. Name **George Bray**
13. Birthplace **Gloucester, Mass.**
14. Maiden Name **Martha Story**
15. Birthplace **Essex, Mass.**

- 16 (a) Informant **Records-US Marine Hospital**
- (b) Address **Baltimore, Md.**

- 17 (a) **Burial** (b) Date thereof **Oct 24, 1943**
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery **Gloucester, Massachusetts**
Location

- 18 (a) Funeral director **Holt C. B. M. Walters**
- (b) Address **Pratt Street, Md.**

- 19 (a) **OCT 24 1943** (b) **Washington, D.C.**

VS 154

CG 46826

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 23, 1943, 5:15 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **July 6, 1943, to Oct. 23, 1943**, and that I last saw him alive on **Oct. 23, 1943**.

Immediate cause of death
Leukemia, chronic, lymphogenous

Duration
10 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at **M**
- (c) Where did injury occur?
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
- (e) Means of injury (Specify kind of place)

23. Signature

Address **US Marine Hospital**
Baltimore, Md.

Date signed **10/23/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

Caution: When filling out this form, every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09404

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3324 Woodland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

30 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3324 Woodland Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Rebecca Lena Gerber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Maurice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1886

8. AGE: Years

57

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

House Work

FATHER
MOTHER

12. Name

Jacob Rubinstein

13. Birthplace

Russia

14. Maiden Name

Rose ?

15. Birthplace

Russia

16 (a) Informant

Maurice Gerber

(b) Address

3324 Woodland Ave

17 (a)

Burial

(b) Date thereof

Oct, 24, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebrew Herring Run

Location

Bowleys Lane

18 (a) Funeral director

Sol Levinson & Bros

(b) Address

1124 1126 W North Ave

19 OCT 24 1943

1 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 22, 1943, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1943, to Oct. 21, 1943, and that I last saw him alive on Oct. 21, 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Arteriosclerotic Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Samuel M. Wolfe

Address

1331 E. North Ave

Date signed (M.D.)

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution:
Monument & Rutland Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Eli Stein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 17, 1898

8. AGE: Years 45 Months 9 Days 6
If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Grocer Store

11. Industry or business Merchant

12. Name Julius Stein

13. Birthplace Russia

14. Maiden Name Lena Sachs

15. Birthplace Russia

16 (a) Informant Irving Stein

(b) Address 2909 N Pulaski St

17 (a) Burial (b) Date thereof Oct, 24, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory He brew Rosedale Cem
Location Philadelphia Road Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W. North Ave

24 1948 Thurston Williams, M.D.
(Date rec'd by registrar) Registrar

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09405

Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2109 Orleans St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/ 1948 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 10/15 1948 to 11/23 1948,
and that I last saw him alive on 10/23 1948.

Immediate cause of death

Pulmonary Edema

Due to Myocardial Infarction

Due to Coronary Thrombosis

Other Conditions Pneumonia, Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Max R. Goldstein M. D.

Address Sinai Hospital Date signed 10/23/48

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

RECORDS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT			G 09406		
CERTIFICATE OF DEATH 937			Registered No.		
1. PLACE OF DEATH:			2. USUAL RESIDENCE OF DECEASED:		
(a) Baltimore City, Maryland			(a) State <u>Md</u> (b) County		
(b) Street address <u>Levindale Home</u>			(c) City or town <u>Baltimore</u> <u>Bury St</u>		
(c) Hospital or institution: <u>Belvedere & Greenspring Ave</u>			(If outside city or town limits, write RURAL and give town)		
(d) Length of stay in hospital or inst. (yrs., mo., or days)			(d) Street No. <u>2013 Pres bury St</u>		
(e) Length of stay in Baltimore (yrs., mo., or days) <u>35 yrs</u>			(If rural give location)		
3 (a) FULL NAME <u>Annie Fine</u>			(e) Citizen of foreign country? (Yes or No)		
3 (b) If veteran, name war			If yes, name country		
3 (c) Social Security Account No.			MEDICAL CERTIFICATION		
4. Sex <u>Female</u>			20. DATE OF DEATH <u>Oct 22</u> 19 <u>43</u> at <u>1:10 P.M.</u>		
5. Color or race <u>White</u>			21. I certify that death occurred on the date above stated; that I attend-		
6 (a) Single, married, widowed, or divorced. <u>Widow</u>			ed deceased from <u>3-11</u> 19 <u>42</u> , to <u>10-22</u> 19 <u>43</u> .		
6 (b) Name of husband or wife <u>Late Frank</u>			and that I last saw him alive on <u>10-22</u> 19 <u>43</u> .		
6 (c) If alive, give age years			Immediate cause of death <u>Cerebral Arteriosclerosis</u>		
7. Birth date of deceased (mo., day, yr.) <u>1878</u>			<u>Ch. card. vascular disease.</u>		
8. AGE: Years <u>65</u> Months Days If less than one day			Due to		
<u>65</u> hr. min.			Due to		
9. Birthplace <u>Russia</u>			Other Conditions <u>Pyelitis</u>		
(Town, county, and state)			(Include pregnancy within 3 months of death)		
10. Usual Occupation			Date of operation		
11. Industry or business <u>House Work</u>			Major findings of operations		
12. Name <u>Abraham Binder</u>			of autopsy		
13. Birthplace <u>Russia</u>			22. If death was due to external causes, fill in the following:		
14. Maiden Name <u>Lena ?</u>			(a) Accident, suicide, or homicide		
15. Birthplace <u>Russia</u>			(b) Date of occurrence at M		
16 (a) Informant <u>Edward B. Fine</u>			(c) Where did injury occur? (City or town) (County) (State)		
(b) Address <u>3655 Parkheights Ave</u>			(d) Did injury occur about home, on farm, industrial place, in public place? While at work?		
17 (a) Burial (b) Date thereof <u>Oct, 24, 1943</u>			(Specify type of place)		
(Burial, cremation, or removal) (month) (day) (year)			(e) Means of injury		
(c) Cemetery or crematory <u>Hebrew Herring Run</u>			23. Signature <u>Edmund Levin</u>		
Location <u>Bowleys Lane</u>			Address <u>Levindale</u> Date signed <u>10/24/43</u>		
18 (a) Funeral director <u>Sol Levinson & Bros</u>					
(b) Address <u>1124 1126 W North Ave</u>					
19 (a) <u>1043</u> (b) <u>Huntington Williams</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		6 09407
CERTIFICATE OF DEATH		937 Registered No.
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:
(a) Baltimore City, Maryland		(a) <u>7</u> Md. (b) County <u>City of Baltimore</u>
(b) Street address <u>4221 Wickford Road</u>		(c) City or town <u>City of Baltimore</u> (If outside city or town limits, write RURAL and give town)
(c) Hospital or institution: <u>at home</u>		(d) Street No. <u>4221 Wickford Road</u> (If rural give location)
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>XXXXX</u>		(e) Citizen of foreign country? <u>NO</u> (Yes or No)
(e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>		If yes, name country
3 (a) FULL NAME <u>MARY SKINNER GRAFFLIN</u>		
3 (b) If veteran, name war <u>NONE</u>		3 (c) Social Security Account No. <u>NONE</u>
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced <u>Divorced</u>
6 (b) Name of husband or wife <u>Fred'k. L. Grafflin</u>		
6 (c) If alive, give age <u>XXX</u> years		
7. Birth date of deceased (mo., day, yr.) <u>Feb. 6, 1866</u>		
8. AGE: Years <u>77</u>	Months <u>8</u>	Days <u>16</u> If less than one day hr. min.
9. Birthplace <u>Baltimore, Maryland</u> (Town, county, and state)		
10. Usual Occupation <u>NONE</u>		
11. Industry or business <u>NONE</u>		
12. Name <u>William H. Skinner</u>		
13. Birthplace <u>Dorchester Co., Md.</u>		
14. Maiden Name <u>Martha Ann Wilson</u>		
15. Birthplace <u>Baltimore, Maryland</u>		
16 (a) Informant <u>Miss Eleanor B. Grafflin (daughter)</u>		
(b) Address <u>4221 Wickford Road, City.</u>		
17 (a) <u>Burial</u> (b) Date thereof <u>Oct. 25, 1943</u> (Burial, cremation, or removal) (month) (day) (year)		
(c) Cemetery or crematory <u>Loudon Park</u>		
Location <u>Frederick Ave., Balto., Md.</u>		
18 (a) Funeral director <u>Stewart & Mowen Company</u>		
(b) Address <u>108 W. North Av. (W.F. Wooden, Sup.)</u>		
19 (a) <u>24 1943</u> (b) <u>Huntington Williams, M.D.</u> (c) <u>1403 Park Ave.</u>		
20. DATE OF DEATH <u>10/22/43</u> 19 <u>at 8 P M</u>		
21. I certify that death occurred on the date above stated; that I attended deceased from <u>Jan 1938</u> to <u>10/22 1943</u> , and that I last saw her alive on <u>10/22/43</u>		
Immediate cause of death <u>Myocarditis</u> <u>Atherosclerosis</u>		
Due to		
Due to		
Other Conditions		
(Include pregnancy within 3 months of death)		
Date of operation		
Major findings of operations		
of autopsy		
22. If death was due to external causes, fill in the following:		
(a) Accident, suicide, or homicide		
(b) Date of occurrence at M		
(c) Where did injury occur? (City or town) (County) (State)		
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)		
(e) Means of injury <u>W.H. Moody</u>		
23. Signature <u>W.H. Moody</u>		
Address <u>1403 Park Ave.</u> Date signed <u>10/24/43</u>		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09408

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5512 Mattfeldt Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 years

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No. 220-07-14531

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Daisy H. Albright

6 (c) If alive, give age years

7. Birth date of deceased (mon.-day, yr.) June 12-1871

8. AGE: Years Months Days If less than one day

72 4 9 hr. min.

9. Birthplace Baltimore Co. Md.

10. Usual Occupation Switch-board Operator

11. Industry or business East Electric Co.

12. Name Cyrus Albright

13. Birthplace Pennsylvania

14. Maiden Name (Debra) Fishpaw

15. Birthplace Maryland

16 (a) Informant Mrs. Daisy H. Albright

(b) Address 5512 Mattfeldt Ave.

17 (a) Burial (b) Date of death Oct. 25-1943

(c) Cemetery or crematorium Goodlaw

Location Baltimore Co. Md.

18 (a) Funeral director Burge Funeral Home

(b) Address 3631 Falls Road

(c) Date rec'd by registrar OCT 24 1943

(d) Signature

(e) Signature

(f) Signature

(g) Signature

(h) Signature

(i) Signature

(j) Signature

(k) Signature

(l) Signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(d) Street No. 5512 Mattfeldt Avenue

(e) Citizen of foreign country? No

If yes, name country

(f) If yes, name country

(g) If yes, name country

(h) If yes, name country

(i) If yes, name country

(j) If yes, name country

(k) If yes, name country

(l) If yes, name country

(m) If yes, name country

(n) If yes, name country

(o) If yes, name country

(p) If yes, name country

(q) If yes, name country

(r) If yes, name country

(s) If yes, name country

(t) If yes, name country

(u) If yes, name country

(v) If yes, name country

(w) If yes, name country

(x) If yes, name country

(y) If yes, name country

(z) If yes, name country

(aa) If yes, name country

(ab) If yes, name country

(ac) If yes, name country

(ad) If yes, name country

(ae) If yes, name country

(af) If yes, name country

(ag) If yes, name country

(ah) If yes, name country

(ai) If yes, name country

(aj) If yes, name country

(ak) If yes, name country

(al) If yes, name country

(am) If yes, name country

(an) If yes, name country

(ao) If yes, name country

(ap) If yes, name country

(aq) If yes, name country

(ar) If yes, name country

(as) If yes, name country

(at) If yes, name country

(au) If yes, name country

(av) If yes, name country

(aw) If yes, name country

(ax) If yes, name country

(ay) If yes, name country

(az) If yes, name country

(ba) If yes, name country

(bb) If yes, name country

(bc) If yes, name country

(bd) If yes, name country

(be) If yes, name country

(bf) If yes, name country

(bg) If yes, name country

(bh) If yes, name country

(bi) If yes, name country

(bj) If yes, name country

(bk) If yes, name country

(bl) If yes, name country

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(ii) If yes, name country

(ij) If yes, name country

(ik) If yes, name country

09409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09409

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 913 N. 37th Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 6

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Florence Gertrude Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 15-1877

8. AGE: Years Months Days

66

6

6

hr.

min.

9. Birthplace

Baltimore, Maryland

10. Usual Occupation

Home

11. Industry or business

12. Name

Thomas Ryan

13. Birthplace

Ireland

14. Maiden Name

Seabell Wright

15. Birthplace

Pennsylvania

16 (a) Informant

William C. Martin

(b) Address

913 N. 37th Street

17 (a) Burial

(b) Date thereof

Oct. 25-1943

(c) Cemetery or crematory

Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

Surgee Funeral Home

(b) Address

3634 Holly Road

19 (a) 1943

(b) Registrar

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

913 N. 37th Street

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 21-1943

at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1943 to 10-20-1943 and that I last saw her alive on 10-20-1943.

Immediate cause of death

Coronary Artery Disease

Due to

Due to

Other Conditions

Hypertension

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type)

While at work?

(e) Means of injury

23. Signature

J. H. H. H. H.

Address

3634 Holly Road

Date signed

10/25/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE BALTIMORE CITY HEALTH DEPARTMENT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09410

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **3rd**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County **Harford**
(c) City or town **Joppa**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3613 Brooklyns Ave**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Walton Foster Bucey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days **3 wks** If less than one day hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Elmer Bucey

13. Birthplace

Md

14. Maiden Name

Dorothy Schiffer

15. Birthplace

NY

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Oct 25 1943**
(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

Charles P. Towell
2427 Edmondson Ave

19 (a) **1943**

(b) Date of registration

Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 22 1943** at **11:55 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 22 1943** to **Oct 22 1943**, and that I last saw him alive on **Oct 22 1943**.

Immediate cause of death **Cardio-Respiratory failure**

Due to **septicemia + toxicity**

Due to **cellulitis of abdomen. Well**

Due to **radical pneumonia & early gangrene**

Other Conditions

History of convulsions.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Helen Bowie**

Address **Johns Hopkins Hosp** Date signed **10/23/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09411

442 486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09411

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *897 Fairmount Ave*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Separated

6 (b) Name of husband or wife

6 (c) If alive, give age *43* years7. Birth date of deceased (mo., day, yr.) *9-2-2 1892*

8. AGE: Years Months Days If less than one day

*51**1**hr.**min.*

9. Birthplace

md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *George Robinson*13. Birthplace *md.*14. Maiden Name *Elizabeth ?*15. Birthplace *md*16 (a) Informant *Receas*(b) Address *JOHNS HOPKINS HOSPITAL*17 (a) *Burial* (b) Date thereof *10-26-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *mt Calvary*Location *A. G. County Md.*18 (a) Funeral director *Adolphus H. H. H.*(b) Address *918 Druid Hill Ave*OCT 24 1943 (b) *Huntington Williams, Jr.*

VS 156

MEDICAL CERTIFICATION

P

20. DATE OF DEATH *Oct-20- 1943 at 4:05 M*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct-7 1943* to *Oct-20 1943*, and that I last saw him alive on *Oct-20- 1943*.

Immediate cause of death

*Coronary Occlusion*Due to *Arteriosclerotic H. D.*Due to *Cardiac Failure*Other Conditions *Pulmonary infarction*

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *8* M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *John R. Birmingham*Address *JH H*Date signed *10-21*

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correctly write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

443119 G 09412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09412
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 720 PENNSYLVANIA AVE

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Hattie Love

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEMALE

5. Color or race

BLACK

6 (a) Single, married, widowed, or divorced.

WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4-17-13

8. AGE:

Years

Months

Days

If less than one day

30

6

3

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

GAS & ELECTRIC

11. Industry or business

FATHER
MOTHER

12. Name

Stephen Wells

13. Birthplace

N.C.

14. Maiden Name

Alice Wells

15. Birthplace

N.C.

16 (a) Informant

(b) Address

Records
JOHNS HOPKINS HOSPITAL

17 (a)

(Burial, cremation, or removal)

(b) Date thereof 10-24-43

(month) (day) (year)

(c) Cemetery or crematory

Teacher

Location

North Carolina

18 (a) Funeral director

(b) Address

Adolphus Salter

918 Druid Hill Ave

19 (a)

(b) Date filed by registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1943 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1943 to Oct 20 1943, and that I last saw her alive on Oct 20 1943.

Immediate cause of death Anuria

at least 2 days

Due to

Sulphathiazole intoxication

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul C. Hatfield

Address Johns Hopkins Hosp.

Date signed 10/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09413
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1327 N. Gilman St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *25 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Balti*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1327 N Gilman St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles Branch

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M.

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

*married*6 (b) Name of husband or wife *Julia M. Branch*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1890

8. AGE: Years Months Days

53

If less than one day

hr. min.

9. Birthplace

Petersburg Va
(Town, county, and state)

10. Usual Occupation

Bus carrier

11. Industry or business

FATHER
MOTHER

12. Name

Moses Branch

13. Birthplace

Petersburg, Va.

14. Maiden Name

Mary Branch

15. Birthplace

Va.

16 (a) Informant

Julia M. Branch

(b) Address

1327 N. Gilman St.

17 (a)

Burial

(b) Date thereof

10-24-43
(month) (day) (year)

(c) Cemetery or crematory

Arbutus

Location

Arbutus, Md.

18 (a) Funeral director

A. Salstead

(b) Address

918 O'neil Hill Ave.

19 (a)

*1943**William M. R.*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-20* 19*43* at *7:15* M21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 2* 19*43*, to *Oct 20* 19*43*, and that I last saw him alive on *Oct 20* 19*43*.

Immediate cause of death

*Aortic Insufficiency**and Coronary Occlusion*

Due to

Patent Ductus

Due to

Other Conditions *Arteriosclerosis**Pulmonary Edema*

(Include pregnancy within 8 months of death)

Date of operation

none

Major findings of operation

none

of autopsy

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

R. J. Young

23. Signature

Address *1424 E. Monument* Date signed *Oct 21* 19*43*

G 09414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09414

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3700 5th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Brooklyn (Balt)
(If outside city or town limits, write RURAL and give town)(d) Street No. 3700 5th St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Robert O Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Eva E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1880

8. AGE: Years Months Days If less than one day
63 5 8 hr. min.9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

12. Name J. R. Wilkinson

13. Birthplace Md

14. Maiden Name Mary Childs

15. Birthplace Md

16 (a) Informant Mrs Eva E Wilkinson

(b) Address 3700 5th St

17 (a) Burial (b) Date thereof 10/26/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director William M. Marack

215 Light St
Huntington, W. Va.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943, 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Oct 23 1943, and that I last saw him alive on Oct 22 1943

Immediate cause of death

Carcinoma of stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. R. Wilkinson M. D.

Address 125 S. Charles St Date signed 10/27/43

Duration

One year

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09415

BALTIMORE CITY HEALTH DEPARTMENT

G 09415

Registered No.

CERTIFICATE OF DEATH

136a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 918 Hollins St., Balt.

(c) Hospital or institution:

Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 918 Hollins St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward W.

Wheatley

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife Elsie Wheatley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-79

8. AGE: Years Months Days If less than one day

64

5

18

19

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Thomas Wheatley

13. Birthplace Md.

14. Maiden Name Mother Abbott

15. Birthplace Md.

16 (a) Informant Katherine Dienstbach

(b) Address 1133 Ashburton St

17 (a) Burial (b) Date thereof 10/19/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

OCT 24 1943 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1943 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1943 to 10-23 1943, and that I last saw him alive on 10-23 1943.

Immediate cause of death pyrexia, infection due to, urethral stricture with septicaemia & pneumonia. Due to & pneumonia, abscess.

Duration 15 days

5 days.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-23-43

Major findings of operation: Peritonitis, abscess.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury N.P. Friedman

23. Signature

Address 1319 Light St

M. D.

Date signed

G 09416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09416

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2029 E. Preston St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edna A. Morrison

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced

Widowed

6 (b) Name of husband David Morrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 26 1889

8. AGE: Years Months Days
54 1 26 hr. min.9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Supt. of Cafeteria

11. Industry or business Lyon Cooklin Co.

12. Name Charles Stokes

13. Birthplace Unknown

14. Maiden Name Catherine Longworth

15. Birthplace Va.

16 (a) Informant Mrs. Mabel Ayd

(b) Address 2031 E. Preston St.

17 (a) Burial (b) Date thereof 10/26/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto.
Location Md.

18 (a) Funeral director Wm. Cook Inc

(b) Address 7 St. Paul St.

(c) Date rec'd by registrar (Huntington Williams, M.D.)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1943, at 7:10 PM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Fracture of
skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury October 22, 1943 6:50 PM

(b) Where did injury occur? Hanover + Co. Store

(c) Did injury occur at home, on farm, industrial place, in public
place? Public place While at work?

(d) Means of injury Struck by street car

23. Signature Robert L. Cook M.D.

Date signed October 23, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09417	Registered No.
CERTIFICATE OF DEATH		94a	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>MD</u> (b) County <u>Balt</u>	
(b) Street address <u>1825 Jackson St</u>		(c) City or town <u>Balt</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution:		(d) Street No. <u>1825 Jackson St.</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>7</u>		(e) Citizen of foreign country? <u>No</u> (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days):		If yes, name country:	
3 (a) FULL NAME <u>Adolph A. Sakowski</u>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced <u>Married</u>	
6 (b) Name of husband or wife <u>Elizabeth Sakowski</u>		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>Nov 15th 1888</u>			
8. AGE: Years <u>54</u> Months <u>11</u> Days <u>6</u> If less than one day hr. min.			
9. Birthplace <u>Germany</u> (Town, county, and state)			
10. Usual Occupation <u>Rigger</u>			
11. Industry or business <u>Bethlehem Fairfield Shipyard</u>			
12. Name <u>Unknown Sakowski</u>			
13. Birthplace <u>Germany</u>			
14. Maiden Name <u>"</u>			
15. Birthplace <u>"</u>			
16 (a) Informant <u>Elizabeth Sakowski</u>			
(b) Address <u>1825 Jackson St</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>10/25/43</u> (Burial, cremation, or entombment) (month) (day) (year)			
(c) Cemetery or crematory <u>Oak Lawn</u> Location <u>Eastern Ave. Extended</u>			
18 (a) Funeral director <u>William Cook Inc</u>			
(b) Address <u>1217 St. Paul St</u>			
19 (a) <u>OCT 21 1943</u> (b) <u>Washington, D.C.</u>			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Oct 21st 1943</u> <u>11:25 A.M.</u>			
21. I certify that death occurred on the date above stated, that I attended deceased from <u>10/19 1943</u> and that I last saw him alive on <u>Oct 21 1943</u>			
Immediate cause of death <u>Coronary occlusion</u>			
Due to <u>943</u>			
Due to <u>"</u>			
Other Conditions			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence <u>"</u> at <u>"</u> M			
(c) Where did injury occur? <u>"</u> (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? <u>"</u> While at work? <u>"</u> (Specify type of place)			
(e) Means of injury <u>"</u>			
23. Signature <u>Dr. Charles S. Charles</u>			
Address <u>1225 O. Charles St</u> Date signed <u>10/21/43</u>			

G 09418

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09418

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

3 (a) FULL NAME

SARA SUNDICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

55

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Porch

13. Birthplace

Russia

14. Maiden Name

Mina

15. Birthplace

Russia

16 (a) Informant

Max Sundick

(b) Address

2023 E. Balto St

17 (a)

Burial

(b) Date thereof 10-24-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Herring Run

Location

Phil Rd & Maryland Ave

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1439 E. Balto St

19 (a)

24 1843 H. H. Williams, Jr.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2023 E. Balto St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-43 19 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-19-1943 to Oct-23-1943. and that I last saw her alive on Oct-23-1943.

Immediate cause of death

Uremia

Duration

2 days

Due to

Chronic nephritis

Due to

General arterio-sclerosis

Other Conditions

Hemiplegia -

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Herman Seid

Address

2404 Entaw Pl

Date signed 10/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correctness. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09419

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

1413 Riverside ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color and race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 24 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

G 09420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09420
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *5-0-4*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1715 N. = Cubbin Street*

(e) Citizen of foreign country (If rural give location)

(f) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME *Mr M^r Gowell*

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1912

8. AGE: Years Months Days If less than one day

31

hr. min.

9. Birthplace *Woodward, S. C.*

(Town, county, and state)

10. Usual Occupation

Labourer

11. Industry or business

12. Name *Wallie McDowell*

13. Birthplace

*S. C.*14. Maiden Name *Martha Jordan*

15. Birthplace

*S. C.*16 (a) Informant *Carrie Jordan*(b) Address *405 New Pittsburg Ave*17 (a) *Burial* (b) Date thereof *10/24/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *Woodward, S. C.*18 (a) Funeral director *Elroy B. Wilson*(b) Address *1000 Brantley Ave*

CT 24 1943

(Date rec'd by registrar) *Washington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-22-1943* at *11 A* M21. I certify that I took charge of the remains described above, held an *autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Meningococcus Meningitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Thomas J. Williams* M.D.Date signed *10-22-43*

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09421

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hosp. 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1305 Daniel Hill Ave.*

(e) Citizen of foreign country? *No.* (Yes or No)

If yes, name country

3 (a) FULL NAME

Bettie Shepherd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Steven

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 2, 1871

8. AGE: Years Months Days

62 6 19 less than one day *18* min.

9. Birthplace

Accomac Co. Va.

10. Usual Occupation

Housewife

12. Name

James Hard

13. Birthplace

Accomac Co. Va.

14. Maiden Name

Julia Bitts

15. Birthplace

Accomac Co. Va.

16 (a) Informant

Marion Barton

(b) Address

1305 Daniel Hill Ave.

17 (a)

Burial (b) Date thereof *Oct. 24, 1943*

(c) Cemetery or crematory

St. Anthony's Cem.

Location

Baltimore, Md.

18 (a) Funeral director

Mr. George J. Halland

(b) Address

1305 Daniel Hill Ave.

(c) Date rec'd by registrar

Oct 24 1943

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 31, 1943 at *5:30* P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 20* 19*43*, to *Oct. 24* 19*43*, and that I last saw her alive on *Oct. 21* 19*43*.

Immediate cause of death

Myocardial Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Oct. 21, 1943*

Major findings of operations *Pericarditis*

Intestine - extensive

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(a) Means of injury

23. Signature *C. F. Richter*

Address *St. Joseph's Hosp.*

Date signed *10/31/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09422
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 3710 2nd St. Brooklyn Md

(c) Hospital or institution:

South Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State M.C. (b) County(c) City or town Luxington
(If outside city or town limits, write RURAL, and give town)(d) Street No. Route 5
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME JOSHUA CURRAN CRAVER

3 (b) If veteran, name war

3 (c) Social Security Account
No. 244-03-9631

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-19068. AGE: Years Months Days If less than one day
37 4 23 hr. min.9. Birthplace Davidson North Carolina
(Town, county, and state)10. Usual Occupation Instrument Man - Battleground11. Industry or business Fairfield12. Name Curran P. Craver13. Birthplace Davidson North Carolina14. Maiden Name Mary Alice Clodfelter15. Birthplace Davidson North Carolina16 (a) Informant Mal P. Craver(b) Address Davidson North Carolina17 (a) Burial (b) Date thereof Oct 27-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Reed's Baptist Cem.
Location Davidson - North Carolina18 (a) Funeral director Ellsworth Armacost(b) Address 3911 Liberty Heights AveOct 25 1943 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943 at 11:45 PM21. I certify that I took charge of the remains described above, held an
inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 10-23-43 11:30 PM(b) Where did injury occur? 3700 6th Avenue(c) Did injury occur at home, on farm, industrial place, in public
place? public While at work?(d) Means of injury pedestrian struck by auto23. Signature H. G. Wallenwien, M.D.
Medical ExaminerDate signed 10-24-43

09423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 09423

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County Hayford.(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

ELMER CHEEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1924

8. AGE:

Years

Months

Days

If less than one day

19

hr.

min.

9. Birthplace

Sparta N. Carolina
(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

Farm

FATHER

12. Name

Walter Cheek

13. Birthplace

N. Carolina

MOTHER

14. Maiden Name

Irene Warden

15. Birthplace

N. Carolina

16 (a) Informant

Leonard Spurlin

(b) Address

Bel Air Md.

17 (a)

Burial

(b) Date thereof

10/27/43
(month) (day) (year)

(c) Cemetery or crematory

Location

Sparta N. Carolina

18 (a) Funeral director

H. S. Bailey

(b) Address

Darlington Md.

GT (a) 25 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1943, at 7:25 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-24-43 4 a M.

(b) Where did injury occur? Walworth Rd. near

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?

(d) Means of injury Auto ran into tree

23. Signature H. Z. Wallenhausen M.D.

Medical Examiner

Date signed 10-24-43

42180
09424BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09424
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **3**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1437 E. Baltimore St.**
(If rural give location)(e) Citizen of foreign country? **Yes or No**
If yes, name country **Bosnia**

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account
No. **213-09-3691**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Divorced

6 (b) Name of husband or wife

?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Not known?

8. AGE: Years Months Days

50?

If less than one day

hr. min.

9. Birthplace

Russia
(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Anthony Busnuk

13. Birthplace

Russia

14. Maiden Name

Sylvia ?

15. Birthplace

Russia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial(b) Date thereof **Oct 25-43**
(month) (day) (year)

(c) Cemetery or crematory

Holy Trinity Russian

(d) Location

St. Peter's, Md.

18 (a) Funeral director

John A. Grabianka Jr.

(b) Address

423 S. Park St.**OCT 25 1943****Washington, D.C.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **10/21/43** 19 **43** at **6:45 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 20 19 43** to **Oct 21 19 43**, and that I last saw him alive on **Oct 21 19 43**.

Immediate cause of death

Rheumatic Heart disease**Myocardial failure**

Due to

Died to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **Confirms above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Russell A. NelsonAddress **Johns Hopkins Hosp.** Date signed **Oct 23 1943**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G 09425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09425

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address SARATOGA & CALVERT STS.

(c) Hospital or institution:

MERCY HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS

(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) City or town MD. (b) County BALTO.

(c) City or town BALTIMORE.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1645 N. PAYSON ST.

(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No)

If yes, name country. RUSSIA.

3 (a) FULL NAME

MR. NATHAN BRAGER.

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

MARRIED.

6 (b) Name of husband or wife MRS. DA BRAGER

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) NOV 15, 1878

8. AGE:

Years

Months

Days

If less than one day

69

11

9

— hr.

— min.

9. Birthplace

RUSSIA.

(Town, county, and state)

10. Usual Occupation MANAGER - BRANCH

11. Industry or business

BAKERY.

FATHER

12. Name

MARY FINKELSTEIN

13. Birthplace

POLAND

MOTHER

14. Maiden Name

ISRAEL BRAGER.

15. Birthplace

RUSSIA.

16 (a) Informant RECORD

(b) Address

MERCY HOSPITAL

17 (a)

Burial

(b) Date thereof

OCT 25/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hebur Road

Location Philadelphia Rd

18 (a) Funeral director

S. L. Brown

(b) Address

1124-26 W. North Ave

19 (a)

OCT 25, 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 24/43. 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPTEMBER 19/43 to OCT 24/43, and that I last saw him alive on OCT 24/43.

Immediate cause of death

CARDIAC FAILURE.

Duration

2 DAYS.

Due to CEREBRO-VASCULAR ACCIDENT.

Due to

Other Conditions

NONE.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Mercy Hospital

Date signed 10/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09426

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2904 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Louis Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Late Rachael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1857

8. AGE: Years

86

Months

Days

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Retired

FATHER
MOTHER

12. Name Zeil Cohen

13. Birthplace Poland

14. Maiden Name Unkown

15. Birthplace Poland

16 (a) Informant Sidney Cohen

(b) Address 2904 Reisterstown Road

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof October 25, 1943

(month) (day) (year)

(c) Cemetery or crematory

Bnai Israel Cemetery

Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) OCT 25 1943

(Full name of registrar)

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1943, at 4,10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1943, to Oct 24 1943, and that I last saw him alive on Oct 24 1943.

Immediate cause of death

Acute Bronchopneumonia

Due to

Acute Cerebral Hemorrhage

Due to

Acute Hemiplegia

Other Conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. Hornstein

Address 733 Annapolis St

Date signed

M. D.

10/25/43

09427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 1808 W. Lafayette Ave.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1808 W. Lafayette Ave.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

WALTER
WALTER H. LENHARD

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. 215 - 03 - 6456

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mollie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 8, 1883

8. AGE: Years

60

Months

7

Days

15

If less than one day

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

Vice-President

11. Industry or business

Krestle Co.

FATHER

12. Name W. F. Lenhard

13. Birthplace Balto.

MOTHER

14. Maiden Name Mary L. Pruitt

15. Birthplace Balto.

16 (a) Informant Mrs. Mollie C. Lenhard

(b) Address 1808 W. Lafayette Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

10/26/43

(month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 25 1943

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1943. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Oct 23 1943, and that I last saw him alive on Oct 22 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 50 S. Preston St. Date signed 10/24/43

WETHERBEE FORT

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

99428

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a Registered No. 99428

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *London Ave and Madison*
(c) Hospital or institution: *Maryland General Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County *Balto.*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)
(d) Street No. *3036 Swygum Falls Rd.*
(If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mr. William M. Ehlers (William Martin Ehlers)

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mabel M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb. 2, 1867*

8. AGE: Years

76

Months

8

Days

21

If less than one day

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

FATHER
MOTHER

12. Name

Ehlers

13. Birthplace

--

14. Maiden Name

--

15. Birthplace

--

16 (a) Informant

(b) Address

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

10/26/43

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge Cem.

Location *Pikesville, Md.*

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

OCT 25 1943 *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-23-43* 19 *43* at *4:20 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-13* 19 *43* to *10-23* 19 *43*, and that I last saw him alive on *10-23* 19 *43*.

Immediate cause of death

Coronary Heart Failure

Due to

*Cardiac - Vascular
Renal disease*

Due to

Other Conditions

Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Thomas C. Webster, M.D.

Address

Date signed *10/23/43*

Thos. C. Webster, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

89429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 830 09429

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2134 N. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 N. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

RACHEL E. LANG

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife JACOB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1866

8. AGE: Years 77 Months 1 Days 20 If less than one day hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Ezra Wantz

13. Birthplace Carroll Co., Md.

14. Maiden Name Belinda Brown

15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Howard Lang

(b) Address 2134 N. Smallwood St.

17 (a) Burial (b) Date thereof 10/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Krider's Cem.
Location Westminister, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 OCT 25 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21, 19 43, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 1943, and that I last saw her alive on 10/20, 1943.

Immediate cause of death

Due to Coronary Thrombosis
Organic Chb.

Due to Aortic Sclerosis

Other Conditions Hypertension

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify name of place) While at work?

(e) Means of injury

23. Signature H. S. Gandy -
Address 644 N. North St. Date signed

Duration

7 yrs

7-yr

111

PHYSICIAN

Underline the cause to which death should be charged statistically.

09430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1203 Southview Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Southview Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

KATHERINE E. CUMMINGS

3 (b) If veteran, name war
--

3 (c) Social Security Account
No. --

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife W. Corbin Cummings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/1899

8. AGE: Years Months Days If less than one day
44 0 9 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Charles E. Gambill

13. Birthplace N. C.

14. Maiden Name Bertha M. Meagher

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. W. Corbin Cummings

(b) Address 1203 Southview Rd.

17 (a) Burial (b) Date thereof 10/25/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date rec'd by registrar (b) Signature
OCT 25 1943
Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 21, 19 43, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6/1943 to 10/21/1943, and that I last saw him alive on 10/21/1943.

Immediate cause of death

Metastatic carcinoma of brain.

Due to Ca of urinary bladder.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation June 5, 1943.

Main findings of operation:
Metastatic Ca of brain.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State).
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph A. Barker

Address 1517 8th Ave Date signed 10/24/43

Duration
5/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09431
Registered No.

PRINTED MATTER PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison St. & Linden Ave*

(c) Hospital or institution: *Maryland General*

(d) Length of stay in hospital or inst. *15* or days *2* *✓*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *4221 Mary Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Mrs. Ida Christy*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *Widowed*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec. 25, 1886*

8. AGE: Years *77* Months *9* Days *27* If less than one day, hr. *18* min. *65*

9. Birthplace *Md.*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Richard Britton*

13. Birthplace *Md.*

14. Maiden Name *Mary Smith*

15. Birthplace *Md.*

16 (a) Informant *Mr Earl Christy*

(b) Address *4221 Mary Ave*

17 (a) *Burial* (b) Date thereof *10-25-1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Morelands*
Location *Taylor Ave*

18 (a) Funeral director *Geo S Lepore*

(b) Address *1701-03 N Patt Park Ave*

OCT 25 1943 *Att: Dr. Williams M.R.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/22 1943 12:15 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/17 1943 to 10/22 1943*, and that I last saw him alive on *10/22 1943*

Immediate cause of death *Cerebral thrombosis*

Due to *arteriosclerosis*

Due to

Other Conditions *Chronic Cholecystitis*

(Include pregnancy within 3 months of death)

Date of operation *10/19/43*

Major findings of operations *Hydrops of gall bladder*

of autopsy: *None*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
(Specify type of place)

(e) Means of injury

23. Signature *John D. Young Jr*

Address *Md. Gen. Hosp.* Date signed *10/22/43*

09432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09432
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry of business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery

(d) Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1943. 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage, spontaneous.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

Means of injury

23. Signature

Date signed

Robert L. Graham

Oct. 23 1943

M.D.

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a ✓ G 09433
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 6000 Ballona Ave.
(c) Hospital or institution:
EDGEWOOD SANATARIUM
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balto. City
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Kenoak Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

CATHARINE V. HOFFMAN

3 (b) If veteran, name war
NO

3 (c) Social Security Account
No. NO

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife NO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 78 Months Days If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name DANIEL V. HOFFMAN

13. Birthplace Balto. Md.

14. Maiden Name BARBARA CLINE

15. Birthplace Va.

16 (a) Informant Dr. WM. TARUN

(b) Address 2309 KENOAK ROAD

17 (a) Burial (b) Date thereof OCT 25-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3800 Frederick Ave.

18 (a) Funeral director James C. Mitchell

(b) Address 1900 Eutaw Place.

OCT 25 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1943 19 at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22, 1943, to Oct. 22, 1943, and that I last saw him alive on Oct. 22, 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

Due to Cerebral arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation none

of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank H. Golen

Address 2701 CALVERT ST. Date signed Oct. 24, 1943

Duration

3 hours

2 years

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G 09434

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 206 Taplow Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Taplow Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD B. MEGINNISS

- 3 (b) If veteran, name war no 3 (c) Social Security Account No. DO

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

- 6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1868
8. AGE: Years 74 75 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name Nathaniel T. Meginniss

13. Birthplace Md.

14. Maiden Name ELIZABETH BOYER

15. Birthplace MD.

- 16 (a) Informant THOMAS E. ELY

- (b) Address 2119 Mt. Royal Terrace

- 17 (a) burial (b) Date thereof Oct 25, 1943
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

- 18 (a) Funeral director John Mitchell Bros
(b) Address 1900 EUTAW PLACE

- (c) Date of death OCT 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22, 1943 19 at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1943, Oct. 22, 1943, and that I last saw him alive on Oct. 22, 1943.

Immediate cause of death

Bronchial Pneumonia

Duration

17 days

Due to

Due to

- Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

- Date of operation none

- Major findings of operation: none

- of autopsy: none

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Oden

- Address 2701 N. Calvert St. Date signed Oct 24, 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

09435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09435
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address ~~1427 Bolton St.~~ 308 Windsor Ave.
- (c) Hospital or institution:
NURSING HOME
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County 1427 BOLTON ST.
- (c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1427 BOLTON ST.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

DR. MARY A. WATERS

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. no

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1856

8. AGE: Years Months Days If less than one day

86

11

6

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

retired

11. Industry or business

12. Name DR. EDMUND G. WATERS

13. Birthplace

Md.

14. Maiden Name

MARY A. HITCH

15. Birthplace

Md.

16 (a) Informant HENRY H. WATERS

(b) Address 422 EQUITABLE BLDG.

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof Oct. 25, 1943

(month) (day) (year)

(c) Cemetery or crematory LOUDON PARK CEMETERY

Location 3801 Frederick Ave.

18 (a) Funeral director

(b) Address 1900 EUTAW PLACE

OCT 25 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1943 19 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to 10/23/43, and that I last saw her alive on 10/22/43.

Immediate cause of death

Myocardial
Arterio-sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1403 PARK AVE.

Date signed 10/25/43

Duration

Arterio-sclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09436

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, give RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 22 1943 at 20 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct 16 1943 to Oct 22 1943
and that I last saw him alive on Oct 21 1943

Immediate cause of death

Lobar Pneumonia

Duration

7 days

Due to

Due to

Other Conditions

None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public
place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. C. Pettit

M. D.

Address

817 Hamilton

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 23 1943

Huntington

G 09437

MJ-84240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09437

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 24 W. Lafayette Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sarah Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Arthur Lawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1914

8. AGE: Years Months Days If less than one day

29

2

6

hr.

min.

9. Birthplace Georgia

(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name Willie Lee Lovett

13. Birthplace Georgia

14. Maiden Name Josephine Jones

15. Birthplace Georgia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 10-26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director George S. Kelson

(b) Address 1302 Presstman St

19 (a) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1943 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1943 to 10/23 1943, and that I last saw him alive on 10/23 1943.

Immediate cause of death

Due to Myocardial infarction
Due to Atherosclerosis, L. Ang.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul H. Yattina M.D.

Address B. C. N.

Date signed 10/24/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09438

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 09438
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EARL AYDELOTTE

3 (b) If veteran, name war

3 (c) Social Security Account
No. none4. Sex
Male5. Color or race
Colored6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Ida Aydelotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 19098. AGE: Years Months Days If less than one day
34 4 5 1 hr. min.9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation No occupation

11. Industry or business

12. Name Alex Spriggs13. Birthplace Md.14. Maiden Name Unknown15. Birthplace Md.16 (a) Informant Lee Aydelotte
(b) Address 815 N. Gilmore St.17 (a) Burial (b) Date thereof 10-25-43
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutus Cem
Location md18 (a) Funeral director Rev. D. Kelson(b) Address 1343 Presbman St19 (a) OC (b) William Williams
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-1943 at 11⁵⁵ P M

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions Laceration & abrasion

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury 10-21-43 at 9 P M(b) Where did injury occur at foot of 40 N. Carroll St(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? no(d) Means of injury Pedestrian struck by truck23. Signature William Williams M.D.Date signed 10-22-43

Medical Examiner.

G 09439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09439

Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

W W

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

colored

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

Anna Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov

1896

8. AGE: Years

47

Months

11

Days

hr.

min.

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated that I attend-

ed deceased from 10/15/1983 to 10/24/1983.

and that I last saw him alive on 10/24/1983.

Immediate cause of death

Central

apoplexy x

Due to

Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

39140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 09140
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

4 Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or

divorced Widowed

6 (b) Name of husband or wife Mary Matthews

6 (c) If age, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8, 1881

8. AGE: Years Months Days If less than one day

62 7 14 hr. min.

9. Birthplace Connecticut

(Town, county, and state)

10. Usual Occupation Repairman

11. Industry or business Greenwood - Elliott - Fisher

12. Name John Matthews

13. Birthplace Connecticut

14. Maiden Name Margaret Smith

15. Birthplace Ireland

16 (a) Informant Agnes Gallagher

(b) Address Cape May, N. J.

17 (a) Removal (b) Date thereof Oct 26, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Brooklyn, N. Y.

18 (a) Funeral director Mr. John H. Telford

(b) Address 801 W. Fayette St.

19 (a) Date of death Oct 25, 1943

(b) Time of death 11:00 AM

(c) Cause of death

(d) Manner of death

(e) Signature of physician

(f) Address of physician

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 410 W. Fayette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1943 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8-1943 to 10-22-1943.

and that I last saw him alive on 10-22-1943.

Immediate cause of death

Respiratory failure

Due to Cerebral Vascular

accident

Due to Hypertensive Cerebral

vascular disease

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ralph J. Cheang

Address Univ. Hospital Date signed 10/23/43

09441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09441
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2602 Ken Oak Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2602 Ken Oak Road
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary V.Warner

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W.6 (a) Single, married, widowed, or
divorced.Widow6 (b) Name of husband or wife John F. Warner

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1879

8. AGE: Years Months Days If less than one day

63 64 11 - hr. min.9. Birthplace Baltimore Maryland
(Town, county, and state)10. Usual Occupation Home Duties

11. Industry or business

12. Name William Harris13. Birthplace Baltimore Md14. Maiden Name Phoebe Hampshire15. Birthplace Maryland16 (a) Informant Mrs. Irene Whitehill(b) Address 2602 Ken Oak Road17 (a) Funeral (b) Date thereof Oct 26-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Louden Park CemeteryLocation Baltimore Md.18 (a) Funeral director Mamie Cook Syfer(b) Address 1600 W. North AveOCT 25 1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1943, at 4 30 A M21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury _____

23. Signature Robert L. Eustace M.D.Date signed Oct. 23 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09442

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09442

1. PLACE OF DEATH:
(a) City or town Baltimore
(b) Street address #414 Laurens
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. #414 Laurens
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Obed J. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mary Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 - 1888

8. AGE: Years 55 Months 6 Days 16 If less than one day hr. min.

9. Birthplace Longfester Co.
(Town, county, and state)

10. Usual Occupation Sea Food

11. Industry or business

12. Name Thelouglly Martin

13. Birthplace MD

14. Maiden Name Mary Tracy

15. Birthplace MD

16 (a) Informant Mary Martin

(b) Address #417 Laurens

17 (a) Burial (b) Date thereof 10-26-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory W.D. Auburn

Location Balti. City

18 (a) Funeral director Samuel T. Chas. H.

(b) Address 638 N. Gilman St.

19 (a) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-1943 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19-1943 to 10-22-1943, and that I last saw him alive on 10-22-1943.

Immediate cause of death Cardiac Dilatation

Due to Bronchial Pneumonia 2 dy

Due to Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W.R. Joykin

Address 1135 Gilman Date signed 10/23/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

007 25 1943

G 09443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09443

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 22 S. Athol Ave.
 (c) Hospital or institution:
Gen. German Aged Home
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 432 Drury Lane
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

ANDREAS
Andreas Miedwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Widower

- 6 (b) Name of husband or wife Late Augusta G nee Rohde 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1884

8. AGE: Years 84 Months 3 Days 8 If less than one day 9 hr. 18 min.

9. Birthplace Germany
(Town, county, and state)10. Usual Occupation Carpenter11. Industry or business Retired12. Name George Miedwig13. Birthplace Germany14. Maiden Name Margaret Hermann15. Birthplace Germany16 (a) Informant Mrs. Frank Zimmerman(b) Address 432 Drury Lane17 (a) Burial (b) Date thereof Oct. 25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Druid RidgeLocation Pikesville Md.18 (a) Funeral director Wm. H. Stitzer(b) Address 4101 Edmondson Ave.Oct 25 1943 Washington Williams

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22/43. 19 43 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20/43 to Oct. 22/43. and that I last saw him alive on Oct. 21/43.

Immediate cause of death

Cerebral Hemorrhage.

Due to

Due to Arterio Sclerosis. Unknown.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur?
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature Henry H. Williams
M. D.Address 432 Drury Lane Date signed Oct. 22/43.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09444

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6-09444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1001 Arlington Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Covans
(If outside city or town limits, write RURAL and give town)(d) Street No. 1001 Arlington Ave.
(If rural, give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas Sparrow

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Elizabeth

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) March 13, 1866

8. AGE: Years 77 Months 7 Days 9 hr. min.

9. Birthplace Anne Arundel Co. Md.

10. Usual Occupation

11. Industry or business

12. Name Mrs. C. Sparrow

13. Birthplace Anne Arundel Co. Md.

14. Maiden Name Mary Davis

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Catherine Gray

(b) Address 1001 Arlington Ave.

17 (a) Burial (b) Date of death Oct. 25, 1943
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. W. Holland

(b) Address 1631 Dumbarton Hill Ave.

19 (a) 25-1043 (b) Date of registration

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/1943 at 5 P. M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 10/16/1943 to 10/22/1943,
and that I last saw him alive on 10/21/1943.

Immediate cause of death

Chronic Bright's Disease 14 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. Biddle

Address 450 W. Biddle St Date 10/25/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

G 09445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09445

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

White

Married

6 (b) Name of husband or wife

Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE: Years Months Days If less than one day

62

hr.

min.

9. Birthplace

South America

(Town, county, and state)

10. Usual Occupation

Paint Mfg.

11. Industry or business

12. Name

Joseph

13. Birthplace

South America

14. Maiden Name

Not known

15. Birthplace

South America

16 (a) Informant

Wife

(b) Address

17 (a) Burial

(b) Date thereof 10-25-43

(c) Cemetery or crematory

Wash. Ref.

(d) Location

Silver Spring Ref.

18 (a) Funeral director

Jack Lewis, Inc.

(b) Address

1439 E. Balt St

19 (a)

Dr. H. H. Williams, M.D.

(b) Date rec'd by registrar

10-25-43

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1701 Edlaumont St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/23/43 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10/13/1943 to 10/23/1943.

and that I last saw him alive on 10/23/1943.

Immediate cause of death

Shock

Due to

Hemorrhage

Due to

Post operative abdominal-peritoneal abscess

Other Conditions

Cecum of colon

(Include pregnancy within 3 months of death)

Date of operation

10/22/43

Major findings of operation

Carcinoma of colon

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

OCT 25 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09446
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: *Monument St*
(c) Hospital or institution: *Sinai Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Balto*
(If outside city or town limits, write RURAL, and give town)
(d) Street No. *2223 E. Balto St*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ISRAEL D. STEINBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband or wife *Rose* 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1876*

8. AGE: Years *67* Months Days If less than one day hr. min.

9. Birthplace *Russia*
(Town, county, and state)

10. Usual Occupation *Retired Coal Miner*

11. Industry or business

12. Name *Nathan*

13. Birthplace *Russia*

14. Maiden Name *Trunk*

15. Birthplace *Russia*

16 (a) Informant *Ralph Steinberg*

(b) Address *5115 Sunset Rd.*

17 (a) *Burial* (b) Date thereof *10-25-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Horseshoe*

Location *Phy Rd. & Hamilton Ave*

18 (a) Funeral director *First Service Inc.*

(b) Address *1439 E. Balto St*

19 (a) *Huntington Williams, M.D.* (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/24* 19*43* at *10:45* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *10/10* 19*43* to *10/24* 19*43*, and that I last saw him alive on *10/23* 19*43*.

Immediate cause of death *Acute Coronary Thrombosis?*

Due to *Hypertensive Pulmonary C-V disease*

Due to

Other Conditions *B.P.H.*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Raymond B. Shulberg*

Address

Date signed *10/24/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a
G 09447
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 4915 Pennington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4915 Pennington Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Antoni Kowalczyk

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-18-6814

4. Sex

m.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Not Known

8. AGE:

Years

Months

Days

If less than one day

about 54

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

Fireman

11. Industry or business

FATHER

12. Name

13. Birthplace

Poland

MOTHER

14. Maiden Name

15. Birthplace

Poland

16 (a) Informant

Leo Kowalczyk

(b) Address

2522 1st St

17 (a)

Burial

(b) Date thereof 10-25-43
(month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

Ritchie Highway

18 (a) Funeral director

W. S. Fialkowski

(b) Address

2007 Eastern Ave

19 (a) 25 1943

Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1943 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1943 to 10/22 1943 and that I last saw him alive on 10/22 1943.

Immediate cause of death

Due to

Coronary Heart

Due to

11 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Samuel Aul

M. D.

Address 23 Balgownie Date signed

G 09448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09448

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1329 Glydon Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1329 Glydon Ave.
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1889

8. AGE:

54

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Lith

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Frank Szidelys

(b) Address 1329 Glydon Ave.

17 (a) Burial (b) Date thereof 10-26-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy Redeemer Cn.
Location Blain Rd.

18 (a) Funeral director Joseph Kasnakos

(b) Address 607 Washington St.

19 (a)

OCT 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/43 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/43 to 10/22/43 and that I last saw him alive on 10/22/43

Immediate cause of death

Acute Cardiac Failure

Duration

1 day

Due to Hypertensive Cardiac Failure

Due to Aneurysm

1 day

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Joseph S. Lawkatz

M. D.

Address 607 Washington St. Date signed 10/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09449

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4 Sex

5 Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7 Birth date of deceased (mo., day, year)

8 AGE: Years Months Days If less than one day

9 Birthplace

10 Usual Occupation

11 Industry or business

12 Name

13 Birthplace

14 Maiden Name

15 Birthplace

16 (a) Informant

(b) Address

17 (a) Date of death

(b) Date thereof

(c) Cemetery or cremation

Location

18 (a) Funeral director

(b) Address

19 (a) Date received

(b) Signature

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended

deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

10 yrs

???

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

OCT 25 1943

John Williams, M.D.

John F. Furbey, M.D.

Address

Date signed

G 09450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09450
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Cass(c) City or town Paradise
(If outside city or town limits, write RURAL and give town)(d) Street No. Green
(If rural give location)(e) Citizen of foreign country? Yes or No
If yes, name country3 (a) FULL NAME BEATRICE M COLLINS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 18 19438. AGE: Years Months Days If less than one day
7 5 hr. min.9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name FRANK MALCZWSKI13. Birthplace BALTO. MD14. Maiden Name MARY WEINHOLD15. Birthplace BALTO. MD16 (a) Informant MARY COLLINS(b) Address BREEN HAVEN MD17 (a) BURIAL (b) Date thereof 10/25/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory SACRED HEART OF MARY
Location GERMAN HILL RD18 (a) Funeral director Laurea F Hoffman(b) Address 1639 Broadway

19 (a) (b) Registrar

OCT 25 1943 Livingston Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943 at 2:3021. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pneumonia lobularDue to W whooping cough

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.Date signed 10-24-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09451

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Wilkins & Caton Ave.*
(c) Hospital or institution: *St. Agnes Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *20*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County
(c) City or town *Balto.*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2102 Eagle Street*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Lois Maitha Steiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept. 25 - 42*

8. AGE: Years Months Days If less than one day

1 *9* *28* *hr.* *min.*

9. Birthplace *Balto., Md.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) *BURIAL*

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

OCT 25 1943

VB 154

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 23* 19*43* at *11 P* M

21. I certify that death occurred on the date above stated, that I attended deceased from *10/23 1943* to *10/23 1943*, and that I last saw her alive on *10/23 1943*.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Arthur Rossberg*

Address *St. Agnes Hosp.* Date signed *10/24/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09452
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3042 Fleetwood

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Juliana Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(a) 25 1943

(Date rec'd by registrar)

(b) Huntingtor Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20, 1943 to Oct 22, 1943

And that I last saw him alive on Oct 22, 1943

Immediate cause of death

Isotonic Parenchyma

Due to

Due to

Other Condition

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

09453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09453

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore,

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1744 E. Lombard St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CATHERINE GREEN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife

Harry Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 13, 1875

8. AGE:

Years

Months

Days

If less than one day

67

10

8

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Henry Bernhardt

13. Birthplace

Germany

14. Maiden Name

Sally Icefeldt

15. Birthplace

Germany

16 (a) Informant: Miss Julia Bernhardt

(b) Address

Eudowood San. Towson, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 25, 1943

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn Cem.

Location

Balto., Md.

18 (a) Funeral director

Philip Herwig Sons.

(b) Address

2024 Orleans St.

19 (a)

OCT 25 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1943, at M

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

Hugh B. McVally, M.D.

23. Signature

Per *Thomas J. Williams*

M.D.

Date signed October 23, 1943

09454 Med Exam cert

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09454
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **710 N. Cary St**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Reed

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1-25-33**

8. AGE: Years Months Days If less than one day

9 **10** **11** **26** hr. min.

9. Birthplace

Richmond, Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name **Mason Reed**13. Birthplace **Va**14. Maiden Name **Louise Mason**15. Birthplace **Va**

16 (a) Informant

(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Removal**(b) Date thereof **Oct 25-43**
(month) (day) (year)(c) Cemetery or crematory **Richmond, Va**

Location

18 (a) Funeral director

(b) Address **James A. Adams**
142 W. 11th St

19 (a) Date of death

Oct 25 1943
10:21 AM
Approved for Dr. Nollen Water

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 21** 19 **43** **6:20 AM**21. I certify that death occurred on the date above stated; that I attended deceased from **10-21-1943** to **10-21-1943** and that I last saw him alive on **19**Immediate cause of death **Cardio-respiratory failure**Due to **Anemia - severe**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Robert Bowie**Address **Johns Hopkins Hosp** Date signed **10/21/43****Robert L. Graham M.D.**

Duration

12 hrs**years**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09455
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 560 Wrephlin St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 560 Wrephlin St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Rachel R. Henry Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female Colored

Widow

6 (b) Name of husband or wife

Charles Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 15 - 1876

8. AGE:

Years

Months

Days

If less than one day

67

2

9

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Charles E. Henry

13. Birthplace

Md

MOTHER

14. Maiden Name

Mary E. Perkins

15. Birthplace

Va.

16 (a) Informant

Lottie Winder

(b) Address

560 Wrephlin St

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Oct 28 - 43

(c) Cemetery or crematory

Laurel Ave

Location

18 (a) Funeral director

James Adams

(b) Address

142 Wrephlin St

19 (a)

(Date of death)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 24 1943 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1943 to Oct 24 1943 and that I last saw her alive on Oct 21 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(c) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

H. G. Pelletier

M. D.

Address

817 Wrephlin St

Date signed

OCT 25 1943

G 09457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09457
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2 E BITTINGS.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Joseph Kavesan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

ROSE KAVESAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JAN 2 - 1880

8. AGE:

Years

Months

Days

If less than one day

63

9

22

hr.

min.

9. Birthplace

HUNGARY

(Town, county, and state)

10. Usual Occupation

Glasgow

11. Industry or business

FATHER
MOTHER

12. Name

Not known

13. Birthplace

Hungary

14. Maiden Name

Not known

15. Birthplace

Hungary

16 (a) Informant

Rose Kavesan

(b) Address

2 E BITTINGS ST

17 (a) Burial

(b) Date thereof 008 28 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

A 4 B

18 (a) Funeral director

Bernard C. Harlan

(b) Address

121 E. Pratt St

OCT 25 1943

(b) Huntington, Md., Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 24 1943 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 16 1943 to 10 - 24 1943, and that I last saw him alive on 10 - 24 1943.

Immediate cause of death

Generalized Carcinoma

Duration

Due to

Cancer of Stomach

Due to

Other Conditions

Gen'l. Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 10 - 20 - 43.

Major findings of operations: Ca of Stomach, gastro-hepatic anastomosis - living of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. B. Bellina

Address

St. Joseph's Hosp. Date signed 10/24/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09458

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1932 MAISEL

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1932 MAISEL ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

CATHERINE HAYES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

FEM. WHITE

WIDOW

6 (b) Name of husband or wife

CARROLL HAYES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1852

8. AGE: Years

Months

Days

If less than one day

91

4

22

hr.

min.

9. Birthplace

Ireland.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Bernard. Mc HUGH

13. Birthplace

IRELAND

14. Maiden Name

NOT KNOWN

15. Birthplace

IRELAND

16 (a) Informant MARY JONES

(b) Address 1932 MAISEL ST.

17 (a) BURIAL

(b) Date thereof Oct. 26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

CATHEDRAL

Location

BALTIMORE MD

18 (a) Funeral director

Bernard C. Harris

(b) Address

121 E. North St.

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1943 at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1943 to Oct 22 1943

and that I last saw him alive on Oct 22 43

Immediate cause of death

Senile Pteryx
myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Walter J. Brown

Address 4012 Edmondson Date signed 10/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09459

BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No. 09459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address: St Joseph
 (c) Hospital or institution:
 15400 IV Caroline
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 76
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1210 63rd St.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME Frederick A. Smith
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex M. 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Married
 6 (b) Name of husband or wife. Mamie
 6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1891
 8. AGE: Years 51 Months 10 Days 2 hr. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual Occupation Printer
 11. Industry or business

12. Name Philip Smith
 13. Birthplace Germany
 14. Maiden Name Anna M.
 15. Birthplace Germany

16 (a) Informant Mamie Smith
 (b) Address 1210 63rd St.

17 (a) Burial, cremation, or removal. Burial (b) Date thereof 10/26/43
 (month) (day) (year)
 (c) Cemetery or crematory. Holy Redeemer
 Location. Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Son
 (b) Address 1000 E. 1st St.
 (c) Registrar Huntington Williams, M.D.

OCT 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1943 at M
 21. I certify that death occurred on the date above stated; that I attended deceased from 10-18-1943 to 10-22-1943, and that I last saw him alive on 10-22-1943.

Immediate cause of death: Chronic obstruction
 Due to: Ca of Esophagus
 Due to:
 Other Conditions: Bronchitis Pneumonia

Duration: 3 yrs.

(Include pregnancy within 3 months of death)
 Date of operation 10-20-43
 Major findings of operation: Tracheotomy
 of autopsy:

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
 (e) Means of injury
 23. Signature J. J. Jones, M.D.
 Address 1000 E. 1st St. Date signed 10/23/43

G 09461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09461

Registered No.

1. PLACE OF DEATH: **BALTIMORE CITY.**
 (a) Baltimore City, Maryland
 (b) Street address **2909 CRESTMONT AVE.**
 (c) Hospital or institution: **NONE**
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **12**
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MARYLAND** (b) County
 (c) City or town **BALTIMORE CITY.**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **2909 CRESTMONT AVE**
 (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country

3 (a) FULL NAME **HELEN STACK McNEAL.**

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Michael T. McNeal**
 6 (c) If alive, give age **52 years**

7. Birth date of deceased (mo., day, yr.) **Sept. 14, 1893**

8. AGE: Years **50** Months **1** Days **10** If less than one day hr. min.

9. Birthplace **Baltimore**
 (Town, county, and state)

10. Usual Occupation **House wife**

11. Industry or business

12. Name **Jos. A. Stack**

13. Birthplace **Baltimore**

14. Maiden Name **Sara L. Kirby**

15. Birthplace **Baltimore**

16 (a) Informant **Michael T. McNeal**

(b) Address **2909 Crestmont Ave**

17 (a) **Burial** (b) Date thereof **Oct. 27, 1943**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Cathedral**
 Location **Baltimore**

18 (a) Funeral director **Rita Wiedefeld**

(b) Address **923 Greenmount Ave**

OCT 25 1943 (Date rec'd by registrar) **W. Williams, M.D.** Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH **OCTOBER 24 1943, 7.30 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **AUGUST 28 43** to **OCT. 24 19 43** and that I last saw her alive on **OCT 24 19 43.**

Immediate cause of death
APOPLEXY OCTOBER 24 1943.
CHRONIC MYOCARDITIS

Due to **ARTERIAL SCLEROSIS**

Due to **HYPERTENSION.**

Other Conditions **NONE**

(Include pregnancy within 6 months of death)
 Date of operation **NONE**

Major findings of operations **NONE**

of autopsy **NONE.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **NO**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**
 (Specify type of place)

(e) Means of injury

23. Signature **W. Williams, M.D.**

Address **3013 ST PAUL ST.** Date signed **OCT 24**

Duration

1940

1940

1940.

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The subject's age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09462

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 W. University Pkwy
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Linda Ellen Matson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1943

8. AGE: Years Months Days If less than one day
19 hr. min.

9. Birthplace Baltimore, Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George William Matson

13. Birthplace New York

MOTHER 14. Maiden Name Margaret McCleary

15. Birthplace New York

16 (a) Informant Union Memorial Hosp

(b) Address 33rd & Calvert Sts

17 (a) Burial (b) Date thereof Oct 26, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Barthwood
Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

25 1943 by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1943. 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1943 to Oct. 24 1943 and that I last saw him alive on Oct. 24 1943.

Immediate cause of death Cerebral respiratory failure

Due to Bronchopneumonia, bilateral

Due to Congenital atelectasis, right.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Mungaterra, Jr. M.D.
Address 332 E. University Pkwy Date signed 10-24-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09463
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mo., or days) 42 days
(e) Length of stay in Baltimore (yrs., mo., or days) 42 years

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Mayfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FRANK CICERO

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Barbara Hufnagel

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1895

8. AGE:

Years

Months

Days

If less than one day

48

0

20

hr.

min.

9. Birthplace Cifalo, Italy

(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER

12. Name Charles Cicero

13. Birthplace Sicily, Italy

MOTHER

14. Maiden Name Josephine Madza

15. Birthplace Sicily, Italy

16 (a) Informant Records-US Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 26-1943

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location 4430 Belfir Road

18 (a) Funeral director Joseph Farace, Inc.

(b) Address 2013 Greenmount Ave.

19 (a)

(Date rec'd by)

(b) William M. R.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1943, 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 18, 1943, to October 22, 1943, and that I last saw him alive on Oct. 22, 1943.

Immediate cause of death Mitral incompetency; Duration
Chr. auricular fibrillation;
Cardiac insufficiency Unk.
Due to Rheumatic heart disease,
inactive with deformity of valve, Unk.
pure mitral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address US Marine Hospital
Baltimore, Md.

Date signed 10/23/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

G 09464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09464

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1616 Bolton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ELIZABETH HOPPER

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widow

6 (b) Name of husband or wife

George H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1858

8. AGE: Years

Months

Days

If less than one day

85

hr.

min.

9. Birthplace Richmond, Va.

(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

Mrs. Daniel Bailey

(b) Address

1616 Bolton St.

17 (a) Burial

(b) Date thereof 10/26/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

(b) Huntington Williams, Md.

OCT 25 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1943, to Oct 25, 1943, and that I last saw him alive on Oct 24, 1943.

Immediate cause of death

Carcinoma of Face

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. Pearson

M. D.

Address

2105 Ches

Date signed

Oct 25

1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09465

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3619 Kimble Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3619 Kimble Rd.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

AUGUST CHARLES MUNZNER, JR.

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Fannye B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1877

8. AGE: Years

Months

Days

If less than one day

66

3

4

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Librarian

11. Industry or business Johns Hopkins

12. Name August C. Munzner, Sr.

13. Birthplace Germany

14. Maiden Name Augusta Cook

15. Birthplace U. S. A.

16 (a) Informant Mrs. Fannye B. Munzner

(b) Address 3619 Kimble Rd.

17 (a) Burial (b) Date thereof 10/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 25 1943

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 43 at 5:44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 pm 1943 to 2:40 1943.

and that I last saw him alive on 19

Immediate cause of death

Chronic Myocarditis

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

25 Oct 43

Duration

2 + 3/4

2 + 3/4

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09466
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>Madison St. & Linden Ave</u> (c) Hospital or institution: <u>Maryland General</u> (d) Length of stay in hospital or inst. (you may over days) <u>7 16</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>Life</u>				2. USUAL RESIDENCE OF DECEASED: (a) State <u>Ind</u> (b) County <u></u> (c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>904 Wheeler Ave</u> (If rural give location) (e) Citizen of foreign country? <u>No</u> (Yes or No) If yes, name country <u></u>			
3 (a) FULL NAME <u>Mr. Bertie Evelyn Rothauge</u>							
3 (b) If veteran, name war <u>None</u>				3 (c) Social Security Account <u>No</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6 (a) Single, married, widowed, or divorced. <u>Married</u>			
6 (b) Name of husband or wife <u>Arthur E. Jr.</u> 6 (c) If alive, give age <u></u> years							
7. Birth date of deceased (mo., day, yr.) <u>Feb. 3, 1906</u>							
8. AGE: Years <u>37</u>		Months <u>8</u>		Days <u>21</u>		If less than one day <u>hr.</u> min.	
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)							
10. Usual Occupation <u>Housewife</u>							
11. Industry or business <u></u>							
12. Name <u>Harry M. Tuckey</u>							
13. Birthplace <u>Baltimore, Md.</u>							
14. Maiden Name <u>Wilhelmina Werner</u>							
15. Birthplace <u>Baltimore, Md.</u>							
16 (a) Informant <u>Arthur E. Rothauge, Jr.</u> (b) Address <u>904 Wheeler Ave.</u>							
17 (a) Burial <u></u> (b) Date thereof <u>Oct. 27, 1943</u> (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory <u>Mea dowridge</u> Location <u>Elkridge, Md.</u>							
18 (a) Funeral director <u>Wm. J. Tickner & Sons,</u> (b) Address <u>North & Pa. Aves</u>							
19 (a) <u>OCT 25 1943</u> Registrar <u>William M. D.</u>							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>10/24 1943</u> <u>4:50 PM</u> 21. I certify that death occurred on the date above stated; that I attended deceased from <u>10/17 1943</u> to <u>10/24 1943</u> and that I last saw him alive on <u>10/24 1943</u> . Immediate cause of death <u>Pulmonary Embolus</u> Due to <u>Left femoral thrombophlebitis</u> Due to <u>Postoperative hemorrhage & pelvic peritonitis</u> Other Conditions <u>Pelvic Ulcer</u> (Include pregnancy within 3 months of death) Date of operation <u>10/17 (2)</u> Major findings of operation: <u>Pulmonary Ulcer (2)</u> of autopsy: <u>Senile aneurysm</u> 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence <u></u> at <u>M</u> (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? <u>While at work?</u> (Specify type of place) (e) Means of injury 23. Signature <u>John D. Young Jr.</u> Address <u>Med. Soc. Hesp.</u> Date signed <u>10/24/43</u>							

09467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09467
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 224 Otterbein Street
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 21
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Baltimore County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, give RURAL and give town)
- (d) Street No. 224 Otterbein
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Nora Randall

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 2 1896

8. AGE: Years

47

Months

7

Days

20

If less than one day

hr.min.

9. Birthplace

md
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Abraham Scilow

13. Birthplace

md

14. Maiden Name

Ann F Ward

15. Birthplace

md

16 (a) Informant

Herman Fitzhugh

(b) Address

302 Otterbein Street17 (a) Burial

(b) Date thereof

Oct 26 43
(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

A.A. Co. Md.

18 (a) Funeral director

Charles L Brown, Jr.

(b) Address

108 W Montgomery St

19 (a)

Huntington Halliday, M.D.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/22/43 at 1:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1943 to 10/22 1943 and that I last saw him alive on 10/24 1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 1131 Harlem Ave Date signed 10/27/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 26 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09468

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw h.

Immediate cause of death

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

1 year

1 week

1 week

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 25 1943

For Registrar

Address 713 Argus St Date signed 10/26/43

SECRETARY RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

0946541586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09469
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **448 Cumming St**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Linda Gloria Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female Black

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **9-19-43**

8. AGE: Years Months Days If less than one day
1 34 hr. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

12. Name

Leon Bell

13. Birthplace

Md

14. Maiden Name

Betty Weaver

15. Birthplace

Md

16 (a) Informant

Roscoe

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location **JOHN HOPKINS MEDICAL SCHOOL OCT 25 1943**

18 (a) Funeral director

Commissioner of Health

OCT 25 1943

Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 23 1943 at 5:20 AM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 20 1943** to **Oct 23 1943**, and that I last saw him alive on **Oct 23 1943**.

Immediate cause of death

Menstruation

Due to

Pneumonia

Due to

Other Conditions

Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Allen Bowie**

Address **Johns Hopkins Hosp.**

Date signed **10/23/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED FOR BINDING

442245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 120

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHN HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town Sp R

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2917 Wells ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

BARBARA JEAN SMITH

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-18-43

8. AGE:

Years

Months

Days

If less than one day

21

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Cecil A Smith

13. Birthplace

PA

14. Maiden Name

JOHNSON

15. Birthplace

PA.

16 (a) Informant

(b) Address

Records

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory.

Location JOHN HOPKINS MEDICAL SCHOOL OCT 25 1943

18 (a) Funeral director

Commissioner of Health

(b) Address

OCT 25 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8

1943, 440 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1943, to Oct 8 1943, and that I last saw her alive on Oct 7 1943.

Immediate cause of death

Intestinal Obstruction

Due to

Due to

Other Conditions

Prenatal Dehydration

(Include pregnancy within 3 months of death)

Date of operation

10/7/43

Major findings of operation

Obstruction

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Che Randol

Address Johns Hopkins Hosp

Date signed 10/11/43

G 09471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09471

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-43

8. AGE: Years Months Days If less than one day
27 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John W. Briscoe

13. Birthplace Balto. Md.

14. Maiden Name Delila Sashins

15. Birthplace Whitestone

16 (a) Informant John W. Briscoe

(b) Address 541 Laurens

17 (a) Burial (b) Date thereof Oct. 25-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 3229 Schroeder St.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

OCT 25 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 541 Laurens St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1943, to Oct. 23 1943, and that I last saw him alive on Oct. 22 1943.

Immediate cause of death

Malnutrition

Due to Deficient diet
Due to Newborn.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signatures

Address Providence Hospital Date signed 10/25/43

Duration

27 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09472
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2712 Edmondson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1876

8. AGE: Years Months Days

If less than one day

67416 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Homemaker

11. Industry or business

FATHER

12. Name

John F. Peters

13. Birthplace

Pa

MOTHER

14. Maiden Name

Margaret Irish

15. Birthplace

Pa

16 (a) Informant

John G. O'Hayer

(b) Address

2712 Edmondson Ave

17 (a)

Buried

(b) Date thereof

Oct 26 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

New Baltimore Ave

Location

Edmondson Ave

18 (a) Funeral director

John G. Moran

(b) Address

3000 E. Baltimore St

OCT 25 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No

2712 Edmondson

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 22

1943, at 8:35 P

21. I certify that death occurred on the date above stated; that I attended deceased from

Aug 1943, to Oct 22 1943

and that I last saw him alive on Oct 22 1943

Immediate cause of death

Carcinoma of sigmoid3 metastases to abdomen

Due to wall

Due to

Other Conditions

Diaphragmatic hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. McCallum

M. D.

Address

3321 Frederick Ave

Date signed

Oct 25, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REASON RESERVED FOR BINDING

G 09473 MJ-83209

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09473
Registered No.MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. 2 mos., 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 10 N. Potomac St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Fannie Dockerty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife George (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1881

8. AGE: Years 82 Months - Days 23

If less than one day hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Isaac Collins

13. Birthplace Maryland

14. Maiden Name Elizabeth Hicks

15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Oct. 26-43

(Burial, cremation, or removal) (month)-(day)-(year)

(c) Cemetery or crematory John A. Collins
Frederick Rd.
Location

18 (a) Funeral director John A. Collins

(b) Address 3000 E. Calhoun St.

19 (c) Hunterdon Williams

OCT 25 1943

VS 166

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1943 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1943 to 10-27 1943, and that I last saw him alive on 10-27 1943.

Immediate cause of death

Arteriosclerosis
PneumoniaDirect cause Arteriosclerosis
Heart disease

Underlying cause Pulmonary infarct

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattman

Address B. C. H. Date signed 10/27/43

Duration

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09474

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 Ainsworth Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 10 mos.

(e) Length of stay in Baltimore (yrs., mo., or days) 14 mos.

3 (a) FULL NAME

Sam Bonfilis Row

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1870

8. AGE: Years

72

Months

10

Days

14

If less than one day

hr.

min.

9. Birthplace Buffalo N. Y.

(Town, county, and state)

10. Usual Occupation

Teacher

11. Industry or business

Religious

FATHER

12. Name John Row

13. Birthplace Germany

MOTHER

14. Maiden Name Margaret Paul

15. Birthplace Germany

16 (a) Informant S. M. Stark Kostka

(b) Address 901 Ainsworth Street

17 (a) Burial

(b) Date thereof Oct 20 1943

(c) Cemetery or crematory North Cliff

Location Green Apts

18 (a) Funeral director Geo M. Frick, Son

(b) Address 811 N. E. Ave

19 OCT 25 1943

VB 144

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County B

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Ainsworth St

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24

1943, at 7:15 A

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Oct. 24 1943, and that I last saw him alive on Oct. 20 1943.

Immediate cause of death

Carcinoma

Due to

Cramp Abdominal

Due to

Metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1106 North Ave

Date signed

10/25/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09 76
609476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G 03 76
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 1-3/4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1280 N. Calvert Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME EDWARD MARSHALL ELLIOTT

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Mary Elliott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/4/91

8. AGE: Years 52 Months 0 Days 21
If less than one day hr. min.

9. Birthplace Tallahassee, Ala.

(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Newsprint-5/15/43

12. Name Marshall Elliott

13. Birthplace Tallahassee, Ala.

14. Maiden Name Willie Hughey

15. Birthplace Tallahassee, Ala.

16 (a) Informant Records, U. S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 10-27-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Graceland Park
Location Columbus Georgia

18 (a) Funeral director A. Lee Odeh

(b) Address 4644 York Road

19 (a) Date rec'd 10/26/43 (b) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 25, 1943, at 12:50M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28, 1943, to Oct. 25, 1943, and that I last saw him alive on Oct. 25, 1943.

Immediate cause of death Adeno Carcinoma
of the rectum with massive
metastasis into the liver

Duration
1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7/3/43-Proctoscopy
with biopsy
Major findings of operation: Carcinoma of
rectum

of autopsy: As above

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Baltimore, Md.

Date signed 10/26/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09477

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution:

Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

3 (a) FULL NAME

Buscemi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-43-1234

8. AGE:

Years

Months

Days

If less than one day

1 29 hr. 30 min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Anthony Buscemi

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Maria Josephine Srobocka

15. Birthplace Baltimore, Md.

16 (a) Informant Parents

(b) Address 1130 Low Street

17 (a) Burial

(b) Date thereof 10/26/43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Holy Redeemer

Location Belair Road

18 (a) Funeral director

Charles E. Schirmer

(b) Address 2601 E. Madison St.

19 (a) Huntington

Baltimore, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State md

(b) County

(c) City or town

Baltimore - 2

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1130 Low Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1943 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24-1943 to 10-25-1943, and that I last saw h.e. alive on 10-25-1943

Immediate cause of death

Crematorium

Due to

Same

Due to

Same

Other Conditions

None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Chas. P. Conroy

M. D.

Address Bon Secours Hospital Date signed 10/26/43

OCT 26 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Westernwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3308 Westernwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Mary (Mamie) Hinkam
3 (b) If veteran, name war No. 3 (c) Social Security Account No. NINE

4 Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Andrew N
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1867

8. AGE: Years 76 Months 11 Days 26 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Andrew

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Myrtle Guderig

(b) Address 3308 Westernwood Ave

17 (a) Burial, cremation, or removal Burial (b) Date thereof 10/26/43
(Month) (day) (year)

(c) Cemetery or crematorium Linden Park
Location Baltimore Md

18 (a) Funeral director Henry G. Guderig

(b) Address 1317 E. Lomb St

19 OCT 26 1943 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943 at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 13 1936 to Oct 23 1943 and that I last saw him alive on Oct 23 1943

Immediate cause of death

Acute myocardial infarct

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jack J. Singer

Address 5062 W. 1st Ave

Date signed 10/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09479

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09479

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5007 Arabia Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. NONE

5. Color of face

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1857

8. AGE: Years 85 Months 10 Days 9 If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date thereof

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

OCT 26 1943

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 24

1943, at 1:45 P

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1943 to Oct 24 1943, and that I last saw him alive on Oct. 23 1943.

Immediate cause of death

Carcinoma of lip.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George Sawyer,

Address

4808 Harford Rd

Date signed

10/24/43

43.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09480

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Balto. Genl Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

50 years

3 (a) FULL NAME

Elizabeth BURKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband

John W. Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

May 13 - 1872

8. AGE: Years

Months

Days

If less than one day

71

7

1012

hr.

min.

9. Birthplace

Pa.

10. Usual Occupation

At home

11. Industry or business

Self

12. Name

Jacob Saken

13. Birthplace

Germany

14. Maiden Name

Elizabeth Gaebe

15. Birthplace

16 (a) Informant

Charles W. Saken

(b) Address

3925 Edmondson Ave

17 (a)

Burial

(b) Date thereof

10/27/43

(c) Cemetery or repository

London Park

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc

19 (a)

1217 St

Huntington Williams, Md.

(b) Date rec'd by registrar

OCT 26 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Balto

(If outside city or town limits, give RURAL and give town)

(d) Street No.

1832 N. Chester St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 25

1943 at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1943 to 10/25 1943, and that I last saw her alive on 10/25 1943.

Immediate cause of death

Respiratory Failure

Due to Congestive myocardial failure

Due to Hypertensive cardiovascular disease

Other Conditions Arteriosclerosis, Hemiplegia left

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Theodore Shrofsky MD

Address West Balto. Genl Hospital signed 10/25/43

M. D.

REPRODUCED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09481

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09481
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Street address

Hospital or institution:

Remond Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

Helen Ligon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife *Wm. Ligon*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb 2 1908*

8. AGE:

Years

35

Months

8

Days

21

If less than one day

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Grant Braxton

13. Birthplace

va

MOTHER

14. Maiden Name

Sadie Barnes

15. Birthplace

md

16 (a) Informant

Sadie Braxton

(b) Address

5220 Denmore ave

17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *10-27-43*

(c) Cemetery or crematory

mt Auburn

Location

md

18 (a) Funeral director

George H. Kilson

(b) Address

1303 Prestman St

19 (a)

(Date rec'd by registrar)

OCT 26 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) *md*

(b) County

(c) City or town

Baltimore

(If outside city or town limit, write RURAL, and give town)

(d) Street No.

5220 Denmore Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 22

19*43*

at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 18* 19*43* to *Oct 22* 19*43* and that I last saw her alive on *Oct 18* 19*43*.

Immediate cause of death

Malignant Hypertension

Due to

Due to

Other Conditions

Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. H. Danfield

Address

Remond Hospital

Date signed

10/26/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09482

443199

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09482
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **Denise Lee Young**

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED6 (b) Name of husband or wife **HAROLD A JR**6 (c) If alive, give age **28** years7. Birth date of deceased (mo., day, yr.) **8-5-17**8. AGE: Years **26** Months **2** Days **20** If less than one day hr. min.

9. Birthplace

ARK

(Town, county, and state)

10. Usual Occupation

H Wife

11. Industry or business

12. Name **Z X FERGUSON**

13. Birthplace

ARK14. Maiden Name **MANIE MYATT**

15. Birthplace

ARK16 (a) Informant **Records**(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **Oct 28/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematorium **Truitt Park**Location **Ark**18 (a) Funeral Director **John O. Mitchell & Son**(b) Address **1900 Eutam Place****OCT 26 1943** (b) **Huntington Millersville, Md**

2. USUAL RESIDENCE OF DECEASED:

(a) State **ARK** (b) CountyCity or town **MARSHALL**

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 25 1943** at **1145 P**21. I certify that death occurred on the date above stated, that I attended deceased from **Oct 20 1943** to **Oct 25 1943**, and that I last saw her alive on **Oct 25 1943**Immediate cause of death **Brain Tumor**

Duration

1 yr

Due to

Due to

over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **Oct 23, 1943**Major findings of operation: **Brain Tumor**

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature **Henry D. Ruppel**Address **Johns Hopkins Hospital**

M. D.

Date signed **10-27-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 09483

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 418 N. Port St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

William Moxley

3 (b) If veteran, name war

3 (c) Social Security Account
No. ---

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie K. Moxley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1869

8. AGE: Years 74 Months 1 Days 25 26 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
Retired

10. Usual Occupation

11. Industry or business

12. Name Walter Moxley
13. Birthplace Balto., Md.

14. Maiden Name Frances Ellison
15. Birthplace Ireland

16 (a) Informant Mrs. Annie K. Moxley
(b) Address 418 N. Port St.

17 (a) Burial (b) Date thereof Oct. 28/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz's Cem.
Location Balto., Md.

18 (a) Funeral director Philip Henry Lord
(b) Address 2024 Orleans St.

19 (a) Date of death Oct 20 1943 (b) Hunterington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1943 19 41 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1942 to Oct 23 1943, and that I last saw him alive on Oct 23 1943.

Immediate cause of death
Acute Myocardial Infarction

Due to Chronic Hypertensive Nephritis

Due to General Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank J. Ayer M.D.
Address 2025 E. Monument St Date signed 10/24/43

Duration
1 year

4 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. 9484

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

3 (a) FULL NAME

Slagle, Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22, 1943

8. AGE: Years Months Days If less than one day

3

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Franklin Slagle

13. Birthplace Baltimore Md

14. Maiden Name Anna Louise Tawney

15. Birthplace Baltimore Md

16 (a) Informant Mrs. Anna Slagle

(b) Address N. Wolfe St. Baltimore Md

17 (a) Burial (b) Date thereof Oct 26/43

(c) Cemetery or crematory Calvary

Location Baltimore Md

18 (a) Funeral director Philip Henry Spaulding

(b) Address 2024 Orleans St

Oct 26 1943

Funeral Home

Funeral Home

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6 N. Wolfe St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1943, at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22, 1943, to Oct 23, 1943, and that I last saw him alive on Oct 25, 1943.

Immediate cause of death

Acute myocardial infarction

Due to No causative organism found as yet.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Acute myocardial infarction

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isabelle Harrison

Address Church Home Hospital Date signed 10-25-43

Duration

5 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09485		BALTIMORE CITY HEALTH DEPARTMENT		G 09485	
		CERTIFICATE OF DEATH		46F	
1. PLACE OF DEATH:			2. USUAL RESIDENCE OF DECEASED:		
(a) Baltimore City, Maryland			(a) State Md (b) County		
(b) Street address 3800 Ridgewood Ave			(c) City or town Baltimore		
(c) Hospital or institution:			(If outside city or town limits, write RURAL and give town)		
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10			(d) Street No. 3800 Ridgewood Ave		
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs			(If rural give location)		
3 (a) FULL NAME			(e) Citizen of foreign country? (Yes or No)		
Moses W. Keller			If yes, name country		
3 (b) If veteran, name war			3 (c) Social Security Account		
			No. 219-12-7999		
4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.			
Male	White	Widower			
6 (b) Name of husband or wife Rosamond K. Keller					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) Dec 6 1867					
8. AGE:	Years	Months	Days	If less than one day	
	75	10	19	hr. min.	
9. Birthplace Frostburg Md					
(Town, county, and state)					
10. Usual Occupation Watchman					
11. Industry or business Enterprize Fuel Co					
12. Name John J. Keller					
13. Birthplace Shepardstown Va.					
14. Maiden Name Lutie Matheney					
15. Birthplace Shepardstown Va.					
16 (a) Informant Harry A. Bentz					
(b) Address 3800 Ridgewood Ave					
17 (a) Burial (b) Date thereof Oct 28 1943					
(Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory Allegany					
Location Frostburg Md					
18 (a) Funeral director Harry H. Hancock					
(b) Address 4204 Ridgewood Ave					
Huntington Williams, M.D. Registrar					
OCT 26 1943					
MEDICAL CERTIFICATION					
20. DATE OF DEATH October 25 1943 at 5:50 P.M.					
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1943 to Oct 25 1943 and that I last saw him alive on Oct 25 1943.					
Immediate cause of death					
Breast Cancer					
Due to					
Due to					
Other Conditions					
(Include pregnancy within 3 months of death)					
Date of operation					
Major findings of operation:					
of autopsy:					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at M					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?					
(e) Means of injury					
23. Signature John J. Baker M.D.					
Address 7503 Park Heights Ave Date signed Oct 26/43					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09486

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: *Providence Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *9 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *9 days*

2. USUAL RESIDENCE OF DECEASED:
(a) State *Md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1724 Llewellyn Ave*
(If rural give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME *Baby Hinton*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *Female* 5. Color or race *negro* 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *10-16-43*

8. AGE: Years Months Days If less than one day
9 hr. min.

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation *Infant*
11. Industry or business

12. Name *William Joseph*

13. Birthplace *Balto, Md.*

14. Maiden Name *Evelyn Hinton*

15. Birthplace *Balto, Md*

16 (a) Informant *Evelyn Hinton*
(b) Address *1724 Llewellyn Ave*

17 (a) *Burial* (b) Date thereof *10/27/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Int. Calvary Cem.*
Location *D. A. County, Ind.*

18 (a) Funeral director *Joseph B. Roberts, Jr.*
(b) Address *1304 E. Central Ave.*

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 25* 19*43*, at *4:30* P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 16* 19*43*, to *Oct 25* 19*43*, and that I last saw her alive on *Oct 25* 19*43*.

Immediate cause of death

Prematurity
Due to

Due to *Asphy*

Other Conditions *Melancholia*

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *W. B. Banfield*
Address *Providence Hospital* Date signed *10/25/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 26 1943

Hinton William, M.D.

G 09487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09487

Registered No.

61

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1251 W. Cross Street

(c) Hospital or institution:

None

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1251 W. Cross Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Mary A. Walsh

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1873

8. AGE: Years 70 Months 6 Days 21 If less than one day hr. min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

12. Name Thomas Walsh

13. Birthplace Ireland.

14. Maiden Name Nora

15. Birthplace Ireland.

16 (a) Informant Miss Anna E. Murphy

(b) Address 1251 W. Cross Street

17 (a) Burial (b) Date thereof 10/28/1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son

(b) Address 301-03 Hollins Street

(Date rec'd by registrar)

(b) Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct 25th, 1943 at 1.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1942 to Oct. 25 1943 and that I last saw him alive on Oct. 25, 1943.

Immediate cause of death

Nephritis

Due to

Chronic nephritis
Cardiac hypertrophy

Due to

Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 107 East West St.

M. D.

October 26, 1943.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09488

BALTIMORE CITY HEALTH DEPARTMENT

G 09488

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 4000 Pimlico Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4000 Pimlico Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Winifred Walther

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Widow

6 (b) Name of husband or wife Charles H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1881

8. AGE: Years Months Days If less than one day

61

10

24

hr.

min.

9. Birthplace Ellicott City, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Silas W. Hazeltine

13. Birthplace Vermont

14. Maiden Name Elizabeth Rutledge

15. Birthplace New Market, Md.

16 (a) Informant Mrs. Grace H. Williams

(b) Address 4000 Pimlico Road

17 (a) Burial (b) Date thereof Oct. 27, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.

(b) Address North & Pa. Aves.

19 (a) (b) Huntington Williams, Md.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1943, 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1942, until 27, 1942, and that I last saw him alive on Oct 25, 1942

Immediate cause of death

Acute heart failure from
General Arteriosclerosis

Due to

Diabetes Mel.

Due to

Other Conditions softening of brain

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature B.S. Marx

Address 116 Cathedral Date signed 10-25-43

Duration

3 years

2 years

1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 26 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G 09489
937

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1807 N. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ELSIE EDITH MURRAY

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Widow

6 (b) Name of husband or wife William Wesley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1884

8. AGE: Years Months Days If less than one day
58 10 21 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John Thomas Chambers

13. Birthplace Carroll Co. Md.

14. Maiden Name Sarah Edith Younger

15. Birthplace Baltimore, Co. Md.

16 (a) Informant Mr. Allen W. Murray

(b) Address 800 Lyndhurst St.

17 (a) (b) Date thereof 10/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) OCT 26 1943
Registrar
William H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1943, at 4:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1943, to Oct 23 1943 and that I last saw him alive on Oct 23 1943.

Immediate cause of death

Acute Cardiac Dehiscence
Due to Myocarditis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harry Glassman M.D.
Address 75 3 W. Fayette St Date signed Oct 26

Duration

3 days

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09490**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2107. E. Eager St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County
(c) City or town **Baltimore.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **# 2107. E Eager St**
(If rural give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country

3 (a) FULL NAME

Walter J. Meehan.

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. **214-03-9987**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Katherine Meehan**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June, 28th, 1896**

8. AGE: Years Months Days If less than one day

47 ~ **46** **43** **26** hr. min.

9. Birthplace **Baltimore, Md.**
(Town, county, and state)

10. Usual Occupation

Plumber

11. Industry or business

12. Name **Walter Meehan Sr.**

13. Birthplace **Baltimore. Md.**

14. Maiden Name **Sarah Hopps.**

15. Birthplace **Baltimore, Md.**

16 (a) Informant **Mrs. Katherine Meehan.**

(b) Address **# 2107 E. Eager. St.**

17 (a) **Burial** (b) Date thereof **Oct. 27/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Holy Redeemer**
Location **Baltimore Rd**

18 (a) Funeral director **Geo. M. Fink & Son.**

(b) Address **# 811 N. Wolfe. St**

19 (a) **Oct 26 1943** **Huntington Williams, M.D.**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct. 24th, 1943** at **10 A.M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 1943** to **Oct 24 1943**, and that I last saw him alive on **Oct 24 1943**.

Immediate cause of death

Chern. Hypertension

Due to

Chern. Hypertension

Due to

Chern. Hypertension due to cerebral hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address **2005 E. Howard St** Date signed **Oct 25/43**

Duration

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09491

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 937

Registered No. G 09491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>33rd St.</u> (c) Hospital or institution: <u>Union Memorial Hospital</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>17</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>17</u>				2. USUAL RESIDENCE OF DECEASED: (a) State <u>La.</u> (b) County _____ (c) City or town <u>Monroe</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>600 Rochelle Ave.</u> (If rural give location) (e) Citizen of foreign country? _____ (Yes or No) If yes, name country _____			
3 (a) FULL NAME <u>Jerome Stacy Bassett</u> 3 (b) If veteran, name war <u>World</u> 3 (c) Social Security Account No. <u>702 - 14 - 0163</u>				MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Oct. 24 1943</u> at <u>3 A M</u> 21. I certify that death occurred on the date above stated; that I attended deceased from <u>Oct. 23 1943</u> to <u>Oct. 24 1943</u> and that I last saw him alive on <u>Oct. 24 1943</u> . Immediate cause of death <u>Respiratory failure</u> Due to <u>cerebral edema</u> Due to <u>Hypertensive cardio-vascular disease</u> Other Conditions _____ (Include pregnancy within 3 months of death) Date of operation _____ Major findings of operations _____ of autopsy _____			
4. Sex <u>M</u> 5. Color or race <u>W</u> 6 (a) Single, married, widowed, or divorced. <u>M</u> 6 (b) Name of husband or wife <u>Ann Bassett</u> 6 (c) If alive, give age _____ years 7. Birth date of deceased (mo., day, yr.) <u>Aug. 13 1886</u> 8. AGE: Years <u>57</u> Months <u>2</u> Days <u>11</u> If less than one day _____ hr. _____ min. _____ 9. Birthplace <u>Sheldon IOWA</u> (Town, county, and state) 10. Usual Occupation <u>Railroad Superintendent</u> 11. Industry or business <u>Railway</u> 12. Name <u>Lauriston L. Bassett</u> 13. Birthplace <u>Ill.</u> 14. Maiden Name <u>Catherine Stacy</u> 15. Birthplace <u>Iowa</u>				PHYSICIAN Underline the cause to which death should be charged statistically. <u>3 yrs.</u>			
16 (a) Informant <u>Mrs. J. S. Bassett</u> (b) Address <u>600 Rochelle, Monroe, La.</u> 17 (a) <u>Removal</u> (b) Date thereof <u>10/26/43</u> (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory <u>Monroe, La.</u> Location _____ 18 (a) Funeral director <u>WM. J. TICKNER & SONS</u> (b) Address <u>Balto., Md.</u>				22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide _____ (b) Date of occurrence _____ at _____ M (c) Where did injury occur? _____ (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place) (e) Means of injury _____ 23. Signature <u>John A. Nesbitt, Jr.</u> M. D. Address <u>Union Memorial Hosp.</u> Date signed <u>10-27-43</u>			

OCT. 26, 1943

Huntington Williams, M.D.
Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09492

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

South Baltimore Sea Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 819 Bretna Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary P. H. Kesselsbrodt

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

George H. Kesselsbrodt

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

May 3, 1903

8. AGE:

Years

Months

Days

If less than one day

40

X0

5

22

hr.

min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual Occupation

Machine Operator

11. Industry or business

FATHER
MOTHER

12. Name

Harvey H. Kesselsbrodt

13. Birthplace

W. Va.

14. Maiden Name

Bessie Snyder

15. Birthplace

W. Va.

16 (a) Informant

Bessie Snyder

(b) Address

1331 Waverly Court

17 (a)

Burial

(b) Date thereof

10/20/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location: Beardsley W. Va.

18 (a) Funeral director

W. J. Emery

(b) Address

1800 Hollins St.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-25-1943, at 7:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull

" Cervical vertebra

Due to

Other Conditions

Fracture; Multiple lacerations, abrasions & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-25- at 7:05 AM

(b) Where did injury occur? Light & Hill Street

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury: Pushed over a truck by street car.

23. Signature: Thomas J. Mulleis M.D.

Medical Examiner.

Date signed 10-25-43

OCT 26 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09493

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09493

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1321 N. Chapel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 20 4 00

3 (a) FULL NAME

PEARL FALLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 13/1879

8. AGE: Years

64

Months

7

Days

10

If less than one day

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

FATHER
MOTHER

12. Name

Mack Potter

13. Birthplace

NC

14. Maiden Name

Maggu P

15. Birthplace

NC

16 (a) Informant

Shelma Hunt

(b) Address

1319 N. Chapel St

17 (a)

Burial

(b) Date thereof

10 28 43

(burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary

Location

A. A. Co

18 (a) Funeral director

Rayner Sanders

(b) Address

1412 E. Pklotok St

19 (a)

OCT 26 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1321 N. Chapel Street

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1943, at 8:20 AM

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mallesio

M.D.

Medical Examiner.

Date signed 10/25/43

G 09494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09494

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

West Baltimore San. Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3805 Sequoia Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

 Aaron Shillman

3 (b) If veteran, name war

3 (c) Social Security Account

No.

No

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1869

8. AGE:

Years

Months

Days

If less than one day

74

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

MOTHER

12. Name

Nathan Shillman

13. Birthplace

Russia

14. Maiden Name

Goleli

15. Birthplace

Russia

16 (a) Informant

Albert H. Shillman

(b) Address

3805 Sequoia

17 (a)

Burial

(b) Date thereof

10-26-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Windsor Hill Rd.

Location

Windsor Hill Rd.

18 (a) Funeral director

Frank Lewis Inc

(b) Address

1439 E. Balto St.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-25-1943, 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death was

IMMEDIATE CAUSE OF DEATH

Pneumo-pneumonia

Due to

Other Conditions *Concussion of Brain -**fractured rib*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *10-18-43 at**7:45 A.M.*

(b) Where did injury occur?

Barison - Norfolk Ave.(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *No*(d) Means of injury *Automobile struck by truck car*

23. Signature

Howard J. Williams

M.D.

Date signed *10-25-43*

Medical Examiner

OCT 26 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09495

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1943, to Oct. 26 1943, and that I last saw her alive on Oct. 25 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

OCT 26 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09496

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09496
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 444 E. 22nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 444 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Donnelly
3 (b) If veteran, name war No
3 (c) Social Security Account No. 213-01-1892

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced SINGLE
6 (b) Name of husband or wife * *
6 (c) If alive, give age * years
7. Birth date of deceased (mo., day, yr.) OCT 12-1968
8. AGE: Years 32 Months - Days 12 If less than one day hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation OFFICE WORK
11. Industry or business BECKLEHEM STEEL-SPR. PK

12. Name GEORGE F. DONNELLY
13. Birthplace BALTIMORE
14. Maiden Name MARY T. MCCAYREY
15. Birthplace BALTIMORE

16 (a) Informant MARY DONNELLY CONNOR
(b) Address 444 E 22ND STREET

17 (a) BURIAL (b) Date thereof 10/27/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHARICAL
Location Old Frederick Road

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) OCT 26 1943 (Date rec'd by registrar)
Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24-1943 at 7:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxiation
Carbon monoxide
Due to illuminating gas.

Other Conditions Confoundant

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-24-43 at P. M.
(b) Where did injury occur? 444 E. 22nd Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury asphyxiation: kitchen gas range

Signature Horace J. Wieders M.D.
Date signed 10-25-43 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09497

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09497

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address L. M. H.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (see 12 or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County Baltimore

(c) City or town Towson
(If outside city or town limits, write RURAL and give town)

(d) Street No. 220 Ridge Ave
(If rural give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3 (a) FULL NAME

Marjorie Helen Buschar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced -

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1930

8. AGE: Years Months Days If less than one day
13 5 18 12 hr. min.

9. Birthplace New York

(Town, county, and state)

10. Usual Occupation school girl

11. Industry or business

12. Name Herbert H. Buschar

13. Birthplace Minnesota

14. Maiden Name Grace M. Meyers

15. Birthplace Bronx, N.Y.

16 (a) Informant parents

(b) Address 220 Ridge Ave - Towson, Ind.

17 (a) Cremation (b) Date thereof Oct. 27, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Crematory
Location Baltimore, Maryland

18 (a) Funeral director John Burns Sons

(b) Address Towson, Maryland

19 (a)

OCT 26 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1943, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 - 1943 to Oct 25 1943, and that I last saw her alive on Oct 25 1943

Immediate cause of death

Leukemia, Acute

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John A. Hasbick, M.D.

Address Union Hospital Date signed 10-27-43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09498
Registered No.MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Savoy & Calvert*

(c) Hospital or institution:

Mary Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*(e) Length of stay in Baltimore (yrs., mos., or days) *1 day*

3 (a) FULL NAME

Baby Girl Custer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1 day

8. AGE: Years

Months

Days

If less than one day

17 hr.

min.

9. Birthplace

Balto. md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

John Custer

13. Birthplace

Baltimore, md.

14. Maiden Name

Helen Goetz

15. Birthplace

Balto.

16 (a) Informant

John Custer

(b) Address

2844 Woodbrook Ave.

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL OCT 26 1943*

18 (a) Funeral director

Commissioner of Health

(b) Address

19

*OCT 26 1943**Huntington Williams, M.D.*

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2846 Woodbrook Ave

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

*10/14 1943 3:55 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *10/13 1943* to *10/14 1943* and that I last saw him alive on *10/14 1943*.

Immediate cause of death

Duration

Due to

Intra-cranial

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul B. Custer

M. D.

Address

Date signed *10/15/43*

G 09139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Cambridge Arms Apt

(b) Street address

Charles & 34th Sts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12(e) Length of stay in Baltimore (yrs., mos., or days) About 66 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Charles & 34th Sts.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

S. Frank Pearson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Grace E. Krager

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE:

Years

Months

Days

If less than one day

About 66

--- hr.

--- min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Jeweler

FATHER
MOTHER

12. Name

Summerfield Pearson

13. Birthplace

Maryland

14. Maiden Name

Olivia Bangs

15. Birthplace

Maryland

16 (a) Informant Mrs. Grace E. Pearson

(b) Address Cambridge Arms Apartments

17 (a) Burial

(b) Date thereof 10/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge

Location

Pikeville, Md.

18 (a) Funeral director

W. W. Mears & Son

(b) Address

805 N. Calvert St.

19 (a)

(Date)

OCT 26 1943

Huntington Williams, M.D.

Physician

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1943 2:22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Oct 25 1943, and that I last saw him alive on Oct 24 1943

Immediate cause of death

Cerebral embolism
secondary to coronary
arteriosclerosis
Due to
myocardial
infarction
Due to
arterio-sclerosis

Duration

12 hours
2 years
10 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

A. C. Smith

M. D.

Address

450 E. Liberty St.

Date signed

Oct 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09500

00500

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4512 Frankford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4512 Frankford Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Hugo Stab

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1860

8. AGE: Years Months Days If less than one day

83

6

18

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant Margaret Gropman

(b) Address 4514 Frankford Ave

17 (a) Burial (b) Date thereof Oct 27 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director

Leonard R. King

(b) Address 205 Maryland Rd.

19 OCT 26 1943

(Date rec'd by registrar)

William Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1943 at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1941 to Oct 19 1943, and that I last saw him alive on Oct 19 1943

Immediate cause of death

Ch. Myocarditis

Duration

2 years

Due to

Senility.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. S. Harding

Address

4810 Belair Rd

Date signed

M. D.

Oct 21 43

G 09501

BALTIMORE CITY HEALTH DEPARTMENT

G 09501

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mo., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 612 Bartlett Ave
(If rural give location)(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES WILSON BAKER

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 141-16-6346

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1943, at 12:45 PM

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Ida Belle Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1877

8. AGE: Years Months Days If less than one day

651022

hr.

min.

9. Birthplace Philadelphia, Pa.

(Town, county, and state)

10. Usual Occupation Tech.11. Industry or business Hopkins Hospital12. Name Charles Christian Baker13. Birthplace Germany14. Maiden Name Unknown15. Birthplace Unknown16 (a) Informant Mrs. Elsie E. Cadden(b) Address 612 Bartlett Ave.17 (a) Burial (b) Date thereof 10/29/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak Lawn CemeteryLocation Baltimore County, Md.18 (a) Funeral director Henry Sander & Sons, Inc.(b) Address 1849 E. North Ave.19 (a) OCT 26 1943

(Date)

Registrar

VS 161

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Bullet wound of head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury October 25, 1943 M.(b) Where did injury occur? 612 Bartlett Ave(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No(d) Means of injury Shot himself in head23. Signature Robert Lee Graham M.D.Date signed October 25, 1943 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09502
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3807 Fairview Ave.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

DOROTHEA NICKLAS REESCH

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1866

8. AGE: Years Months Days If less than one day

77

—

22

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name August Resch

13. Birthplace Germany

14. Maiden Name Katherine Nicklas

15. Birthplace Germany

16 (a) Informant John B. Nicklas

(b) Address 3807 Fairview Ave.

17 (a) Burial (b) Date thereof 10/27/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address OCT 28 1943 North Ave.

19 (a) (b) (Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1943, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio-sclerotic

cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Date signed October 23, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09503

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address: 34th Charles
 (c) Hospital or institution: at home
 (d) Length of stay in hospital or inst. (yrs., mos., or days): 01
 (e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Md (b) County: Baltimore
 (c) City or town: Baltimore
 (d) Street No.: 34th Charles St
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country:

3 (a) FULL NAME: Blanche King
 3 (b) If veteran, name war: no
 3 (c) Social Security Account No.: none
 4. Sex: Female
 5. Color or race: White
 6 (a) Single, married, widowed, or divorced: Single
 6 (b) Name of husband or wife: none
 6 (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.): October 10 1867
 8. AGE: Years: 76 Months: 0 Days: 15 hr. min.
 9. Birthplace: Baltimore, Md.
 10. Usual Occupation: Retired School Teacher
 11. Industry or business: City of Balt.
 12. Name: Calvin J King
 13. Birthplace: Carroll Co. Md
 14. Maiden Name: Mary L. Goodrick
 15. Birthplace: Balt. Md
 16 (a) Informant: Mrs. Jos. E. Rowe (sister)
 (b) Address: 2807 St Paul St.
 17 (a) Burial (b) Date thereof: 10-27-43
 (c) Cemetery or crematory: Greenmount
 Location: Baltimore
 18 (a) Funeral director: STEWART & MOWEN COMPANY
 (b) Address: (W. F. WOODEN BLDG.) 100 N. NORTH AVENUE
 OCT 26 1943 (b)
 Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH: OCT 20 1943 12 noon
 21. I certify that death occurred on the date above stated; that I attended deceased from OCT 1 1943 to OCT 25 1943, and that I last saw him alive on OCT 20 1943.
 Immediate cause of death: Bronchial pneumonia
 Due to: Chronic obstructive pulmonary disease
 Due to: Arteriosclerosis
 Other Conditions: _____
 (Include pregnancy within 2 months of death)
 Date of operation: _____
 Major findings of operations: _____
 of autopsy: _____
 22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence: _____ at _____ M
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)
 (e) Means of injury: _____
 23. Signature: W. E. Woodson
 Address: _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

G 09504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09504
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No. (If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country? (If rural give location)

(f) If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

19 (a)

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09505

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09505

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Gloria Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female

White

-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 20, 1943

8. AGE:

Years

Months

Days

If less than one day

7

5

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Norman J. Simmons

13. Birthplace

Baltimore, Md

14. Maiden Name

Dorothy Stroman

15. Birthplace

Baltimore, Md

16 (a) Informant

Father

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Mt. Carmel

Location

O'Donnell St.

18 (a) Funeral director

Mr. W. E. D. D. D.

(b) Address

1000 E. D. D. St.

(Date for only registrar)

(b)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2813 O'Donnell St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1943, at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due

to bed clothes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 25, 1943 4 P.M.

(b) Where did injury occur? 2813 O'Donnell St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Entangled in bed clothes

23. Signature Robert Lee F. F. F. M.D.

Date signed October 26, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09506

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2521 W. Fayette Street
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Carrie E. O'Connell

3 (b) If veteran, name war None 3 (c) Social Security Account No. None

4. Sex 71 5. Color or race white 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Daniel J. O'Connell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4th, 1872
8. AGE: Years Months Days If less than one day
71 9 21 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

12. Name John Bentley
13. Birthplace Baltimore, Md

14. Maiden Name Unknown
15. Birthplace Baltimore, Md

16 (a) Informant Mr Stephen O'Connell
(b) Address 2521 W. Fayette Street

17 (a) Burial (b) Date thereof 10/27/1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) (b) Registrar
26 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th, 1943 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21, 1943 to Oct 23, 1943 and that I last saw him alive on Oct 23, 1943.

Immediate cause of death Coroner's of Hamood

Due to

Due to

Other Conditions Post mortem examination
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James H. Cunningham
Address 721 Michael St. Date signed Oct 27, 1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09507

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 5514 Wayne Ave.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County Osecola(c) City or town Kissimmee

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Malloy Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Eleanor Day6 (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) January 20, 1869

8. AGE:

Years

Months

Days

If less than one day

74

9

5

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Retired - Salesman

11. Industry or business

FATHER

12. Name William Day13. Birthplace Maryland

MOTHER

14. Maiden Name Sally E. Malloy15. Birthplace Maryland16 (a) Informant Mrs. Charles M. Day(b) Address 5514 Wayne Ave.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Oct. 27, 1943

(month) (day) (year)

(c) Cemetery or crematory Woodlawn CemeteryLocation Woodlawn, Md.18 (a) Funeral director E. Willis Hamoreau(b) Address 4510 Liberty Heights Ave.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 19 43, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1943 to Oct 25 1943, and that I last saw him alive on Oct 25 1943.

Immediate cause of death

Cardiac ArrestDue to La grippeDue to Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. W. KoonsAddress 806 N. Fulton Ave.Date signed Oct 27, 1943

M. D.

EARLE W. KOONS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 26 1943
 Registrar William M. Day

VS 8

G-09508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09508

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Howard

(c) City or town

Ellicott City, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. Old Frederick Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Clarence Beckman

Clarence E. Beckman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Eva Beckman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1885

8. AGE:

Years

Months

Days

If less than one day

58

-

9

hr.

min.

9. Birthplace Howard County, Md.

(Town, county, and state)

10. Usual Occupation Retired-Former Employee

11. Industry or business Pottery Plant

FATHER
MOTHER

12. Name Edward Beckman

13. Birthplace Howard County, Md.

14. Maiden Name Alberta Day

15. Birthplace Howard County, Md.

16 (a) Informant Mr. Clarence R. Beckman

(b) Address 2518 W. Franklin St.

17 (a) Burial

(b) Date thereof Oct. 27, 1943

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location

Baltimore, Md.

18 (a) Funeral director

W. L. Lammiman

(b) Address 1005 W. Baltimore St.

26 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 23 1943 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1943, to Oct. 23 1943, and that I last saw him alive on Oct. 23 1943.

Immediate cause of death

Cardiac Decompensation

Due to

Emphysema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

M. V. Palmer

M. D.

Address

University Hospital

Date signed

10/28/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09509

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. 219-03-3826

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 17-1899

8. AGE:

Years

Months

Days

If less than one day

44

4

7

hr.

min.

9. Birthplace

N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

10/27/43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 27 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1492 Parish St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 24

1943, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1943 to Oct 24 1943, and that I last saw him alive on Oct 24 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed

10/25/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09510
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 506 Cathedral St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Alice Marie Warr

3 (b) If veteran, name war

3 (c) Social Security Account
No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Bertram Warr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Mary 5/30/1881

8. AGE: Years 62 Months 5 Days 5 If less than one day hr. min.

9. Birthplace Southampton, England
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name George Strugnell

13. Birthplace England

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Bertram Warr

(b) Address 426 E. Pratt St

17 (a) Cremation (b) Date thereof 10/28/43
(burial, cremation, or other) (month) (day) (year)

(c) Crematory or crematory Greenmount

Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) OCT 27 1943 Huntington Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1943, at 3:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.

Date signed October 26, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09511

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address U m H

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1905 Oak Hill Ave City

(If rural give location)

(e) Citizen of foreign country? Naturalized USA (Yes or No)
If yes, name country

3 (a) FULL NAME

William Clark

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. 215-03-1234

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Elizabeth Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 14, 1873

8. AGE: Years Months Days

70512

If less than one day

hr.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual Occupation

Clerical staff @ Hotel Belvedere

11. Industry or business

FATHER
MOTHER

12. Name

John Clark

13. Birthplace

England

14. Maiden Name

Elizabeth

15. Birthplace

England

16 (a) Informant

wife

(b) Address

1905 Oak Hill Ave, City

17 (a)

Burial

(b) Date thereof

10/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery

Parkwood

Location

Parkwood, Md.

18 (a) Funeral director

William Cook Inc

(b)

OCT 29 1943, Paul J

19 (a)

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1943, at 6:20 AM21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1943, to Oct. 26, 1943, and that I last saw him alive on Oct 26, 1943.

Immediate cause of death

Uremia

Duration

Due to Pneumococcus Septic
Type 25Due to Pneumonia - lobar3 hrOther Conditions Cystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Hubert, Jr.Address Union Memorial Hosp Date signed 10-26-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09512

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, year) *Nov 1 - 1888*

8. AGE: Years Months Days If less than one day

54 11 24 hr. min.

9. Birthplace *Balto. Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Frank Danner*

13. Birthplace

14. Maiden Name *Bridget (Unknown)*

15. Birthplace

16 (a) Informant *Nelea Ullman (Sister)*

(b) Address *1403 Clarkson St*

17 (a) *Bureau* (b) Date thereof *10/29/43*

(c) *Brooklyn*

Location *Balto Md.*

18 (a) Funeral director *William Cook Inc*

(b) Address *1217 St Paul St*

19 (a) *Huntington Williams*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *1400* *Clarkson St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 25 1943* at *11:55* P

21. I certify that I took charge of the remains described above, held an *autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to *this* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH *fracture of pelvis; compound fracture of right leg.*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *October 25 1943 8:00* P

(b) Where did injury occur? *Pratt & President Sts*

(c) Did injury occur at home, on farm, industrial place, in public place? *public place* While at work? *no*

(d) Means of injury *Struck by Trailer truck*

23. Signature *Robert Lee Bratton M.D.*
Medical Examiner.

Date signed *October 26, 1943*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09513

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Separated

6 (b) Name of husband or wife

Lucie Franke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: 89 Years 7 Months 0 Days If less than one day hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of death

(b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1738 E. Preston St

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1943, at 10¹⁵ AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1943, to Oct. 26, 1943, and that I last saw him alive on Oct. 26, 1943.

Immediate cause of death

Longestive Heart Failure

Due to Arteriosclerotic C-U Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Same.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

10-26-43

10/29/43

London Park

Balto. Md.

William Cook Inc

217 St. Paul St

10-27-43

Huntington

St. Joseph's Hosp.

10-26-43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09514

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

G 09514

Registered No.

PLACE OF DEATH:

(a) City or town **Baltimore City, Maryland**
 (b) Street address **Wyman Park Drive & 31st St.**
 (c) Hospital or institution:
U. S. Marine Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **6 days**
 (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County _____
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **1016 McKean Avenue**
 (If rural give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3 (a) FULL NAME **HENRY FRANCIS HIMES**

3 (b) If veteran, name war **Peace time Veteran**
 3 (c) Social Security Account No. **219-14-1126**

4. Sex **Male** 5. Color or race **White**
 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Thelma W. Haasloop**
 6 (c) If alive, give age **35** years

7. Birth date of deceased (mo., day, yr.) **May 26, 1907**

8. AGE: Years **36** Months **4** Days **29**
 If less than one day hr. min.

9. Birthplace **Baltimore, Md.**
 (Town, county, and state)10. Usual Occupation **Chief Cook**11. Industry or business **Merchant Marine**12. Name **John N. Himes**13. Birthplace **Baltimore, Md.**14. Maiden Name **Rosa B. Ridgeway**15. Birthplace **Baltimore, Md.**16 (a) Informant **Records, U. S. Marine Hospital**16 (b) Address **Baltimore, Md.**17 (a) **Burial** (b) Date thereof **10/29/43**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery **National**
 Location **Balto. Md.**

18 (a) Funeral director **William Cook Inc**18 (b) Address **217 St. Paul St**19 **CGI 20 1043** **Huntington**

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 25, 1943** at **3:30 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 19, 1943** to **Oct. 25, 1943**, and that I last saw him alive on **Oct. 25, 1943**.

Immediate cause of death **Pneumonia**
bilateral diffuse, with acute
toxic changes in all organs

Due to _____

Due to _____

Other Conditions _____

(Include pregnancies within 3 months of death)

Date of operation **None**

Major findings of operation: _____

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
 (Specify type of place)

(e) Means of injury _____

23. Signature **J. J. T. R. N.**Address **Baltimore, Md.**Date signed **10/26/43**

Duration
Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09515

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5. Color of face

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Date of death

(Burial, cremation, or removal)

(b) Date of death (month) (day) (year)

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1942 to Oct. 25, 1943 and that I last saw him alive on Oct. 25, 1943.

Immediate cause of death

Hemorrhage into abdom. cavity

Due to Metastatic Carcinoma

Due to Carcinoma of uterus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 2, 1943

Major findings of operation: Fibroid uterus with malignant degeneration.

Autopsy: Urination.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

2243 Linden Av.

Date signed

OCT 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09516

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 2900 Evergreen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral Director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1943 to Oct 26 1943, and that I last saw her alive on Oct 25 1943.

Immediate cause of death

Due to

Essential Hypertension

Due to

Other Conditions

Hypertensive Heart Disease

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

G 09517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09517

Registered No.

The
information should be carefully supplied.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 623 St. John's Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

CORA MAY STOCKSDALE

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Silas H. Stocksdale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1866

8. AGE:

Years 77

Months 5

Days 10

If less than one day

hr.

min.

9. Birthplace Friesland, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
MOTHER

12. Name Wilson Keys

13. Birthplace Balto. Co., Md.

14. Maiden Name Mary Ann Gessford

15. Birthplace Pa.

16 (a) Informant Mr. Millard C. Stocksdale

(b) Address 3712 Chesholme Rd.

17 (a) Burial (b) Date thereof 10/27/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Asbury Cem.

Location Reisterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto. Md.

OCT 27 1943 (b)
(Date rec'd by Registrar)

Registrar

VS 150

Thurston M. Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 623 St. John's Rd.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1943 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1942, Oct. 25 1943, and that I last saw him alive on Oct 23 1943.

Immediate cause of death

Acute Pulmonary Edema
Broncho-Pneumonia
Due to Cerebro-Spinal
Arterio-Sclerosis

Due to

Duration

3 days

7 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operations

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 4822 Roland Ave

Date signed 10/25/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09518

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2803 Garrison Blvd.**
(c) Hospital or institution:
Garrison nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days) **26**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **6625 Bushey St.**
(If rural give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3 (a) FULL NAME

Katie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **female** 5. Color or race **white** 6 (a) Single, married, widowed, or divorced **widowed**

6 (b) Name of husband or wife **Henry Jones**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) **Jan. 22, 1868**

8. AGE: Years **75** Months **9** Days **3** If less than one day hr. min.

9. Birthplace **Baltimore Md.**
(Town, county, and state)

10. Usual Occupation **at home**

11. Industry or business

12. Name **Michael Resch**

13. Birthplace **Germany**

14. Maiden Name **Barbara Hoffman**

15. Birthplace **Germany**

16 (a) Informant **George Jones**

(b) Address **6625 Bushey St.**

17 (a) **Burial** (b) Date thereof **10/29/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Oak Lawn**
Location **7225 Eastern Ave.**

18 (a) Funeral director **Clarence F. Hoffmann**

(b) Address **1639 N. Broadway.**

19 (a) (b)
(Signed by registrar)

OCT. 27 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 25** 19**43** **11:30 AM**

21. I certify that death occurred on the date above stated, that I attended deceased from **Sep 1** 19**43**, **Oct 24** 19**43**, and that I last saw him alive on **Oct 24** 19**43**

Immediate cause of death **Cerebral hemorrhage**
Due to **Hypertension**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *Edward A. Ferguson*
Address **1216 W. Hazen St.** Date signed **10/25/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09519
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1115 Rayleigh Way.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

life

3 (a) FULL NAME

Christian Bollack

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. 186-01-1122

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Bertha Bollack

6 (c) If alive, give age

47 years

7. Birth date of deceased (mo., day, yr.)

July 9, 1888

8. AGE: Years

55

Months

3

Days

15

If less than one day

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Foreman

11. Industry or business

Glen L. Martin

FATHER

12. Name John Bollack

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Mary P. Slipper

15. Birthplace Baltimore Md.

16 (a) Informant Bertha V. Bollack

(b) Address 1115 Rayleigh Way.

17 (a) Burial

(b) Date thereof 10/28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

OCT 27 1943

VB 160

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

San Antonio

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1115 Rayleigh Way

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 24 1943 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOT 1941 to Oct. 24 1943.

and that I last saw him alive on Oct 10 43.

Immediate cause of death

Pulmonary edema

Duration 1 hour

Due to

Acute myocardial infarction

Due to

Chronic Coronary atherosclerosis

2 1/2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Louis D. Pollin M.D.

Address

Sparrow Point.

Date signed

10/25/43

Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09520

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2727 E Chase

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

3 (a) FULL NAME

Edward A. Kesser

3 (b) If veteran, name war

3 (c) Social Security Account

No 213-09-3864

4. Sex

M.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Ellen Kesser

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 2/7/1886

8. AGE: Years Months Days If less than one day

57 8 19 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Steel Worker

11. Industry or business

Bethlehem Steel

12. Name

Ellen Kesser

13. Birthplace

Baltimore

14. Maiden Name

Mary E. Kitting

15. Birthplace

Baltimore

16 (a) Informant

Ellen Kesser

(b) Address

2727 E Chase St

17 (a) Burial

(b) Date thereof Oct 29

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore City

Location

City

18 (a) Funeral director

Hillrich Funeral Home

(b) Address

2004 S. Calver St. Baltimore, Md.

19 (a)

(b)

Huntington

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County Balt

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2727 E Chase

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1943 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1941 to Oct. 26 1943 and that I last saw him alive on Oct. 21 1943

Immediate cause of death

Coronary Thrombosis

Duration

5 minutes

Due to

Atherosclerosis

Cardiovascular Disease

5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Signature J. Karl Brown

Address 12127 Patterson

Date signed 10/26/43

M.D.

Ph Ave

OCT 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09521
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) **Burial**(b) Date thereof **OCT 29th**

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) **Huntington Williams, M.D.**

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT 26 1943** at **7:35** M21. I certify that death occurred on the date above stated; that I attended deceased from **OCT 25 1943** to **OCT 26 1943**, and that I last saw him alive on **OCT 26 1943**.Immediate cause of death **Intestinal obstruction.**Due to **Perforated Ca caecum**

Due to

Other Conditions **? Ca prostate**

(Include pregnancies within 3 months of death)

Date of operation **1935-1941**Major findings of operations: **1) Pericardial prosth-tectomy for B.A.H. 2) Perforated Ca caecum of autopsy. None obtained.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address **Johns Hopkins Hospital**Date signed **10/24/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 27 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09522

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Huntington Williams, Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at

2:25 AM

21. I certify that death occurred on the date above stated, that I attended deceased from July 1, 1943, to Oct 26, 1943, and that I last saw him live on Oct 25, 1943.

State cause of death

Cardio-Vascular, 36th.
Ch. Hypertens.
Coronary Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 27 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09523

MD-84344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09523

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., days) 11 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3420 E. Lombard St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Kuchta

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No.

NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife MATILDA KUCHTA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1890

8. AGE: Years Months Days If less than one day

52

10

1

hr

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

CLERK

11. Industry or business

US. GOVERNMENT

FATHER
MOTHER

12. Name Joseph Kuchta

13. Birthplace Germany

14. Maiden Name Marie Schult

15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 29/43

(month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director

Lilly and Ziller INC

(b) Address 403 S. WOLFE ST.

19 (a)

OCT 27 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1943 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1943 to 10-25 1943, and that I last saw him alive on 10-25 1943.

Immediate cause of death

Tubercular TBC

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul H. H. H.

Address 8801

Date signed 10/28/43

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09524

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 S. WOLFE ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 52 YRS.

3 (a) FULL NAME

JOHN PROSSER

3 (b) If veteran, name war

NO

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife MAGDALENE PROSSER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 26 1865

8. AGE: Years

78

Months

54

Days

29

If less than one day

hr.

min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation

CABINETMAKER

11. Industry or business

FATHER
MOTHER

12. Name JOHN PROSSER

13. Birthplace GERMANY

14. Maiden Name ANNA HILTZ

15. Birthplace GERMANY

16 (a) Informant MAGDALENE PROSSER (WIFE)

(b) Address 100 S. WOLFE ST.

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof OCT. 28/43

(month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly and Gecker INC.

(b) Address 403 S. WOLFE ST.

19 (a)

(b) Date of death

OCT 27 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD.

(b) County

BALTO.

(c) City or town BALTIMORE

(If outside city or town limit, write RURAL and give town)

(d) Street No. 100 S. WOLFE ST.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH OCT. 25 1943. at 4/25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Oct 15 1943, and that I last saw him alive on Oct 24 1943.

Immediate cause of death

Cerebral hemorrhage
attained hypertension
Dilatation of heart

Duration

Oct 20 1943

Sept 2 1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George S. Lutz

M. D.

Address 427 S. Calverton Park

Date signed 10/26/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09525
83a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 520 S. WASHINGTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YR S

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 S. WASHINGTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

TENA NOVAK

3 (b) If veteran, name war NO 3 (c) Social Security Account No. NONE

4. Sex FEMALE 5. Color or race WHITE 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife PETER NOVAK 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 4 18 7 3

8. AGE: Years 70 Months 54 Days 20 If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER 12. Name. J. HUDZIK 13. Birthplace GERMANY
MOTHER 14. Maiden Name UNKNOWN 15. Birthplace GERMANY

16 (a) Informant JOSEPHINE DICKEY (DAUGHTER) (b) Address 520 S. WASHINGTON ST.

17 (a) BURIAL (b) Date thereof OCT. 28 / 43 (month) (day) (year)
(c) Cemetery or crematory ST. STANILAUS Location DUNDALK AVE.

18 (a) Funeral director Lilly and Geiler, Inc. (b) Address 403 S. WOLFE ST.

19 (a) OCT 27 1943 (b) Date of death

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH OCT. 24 1943. at 4/10 M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1943, to OCT. 24 1943, and that I last saw her alive on OCT 24 1943.

Immediate cause of death
ARTERIO-SCLEROSIS

Due to CEREBRAL HEMORRHAGE
PARALYSIS

Due to ACUTE MYOCARDIAL
DILATATION

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Kennedy M.D.
Address 3318 N. Elderly St. Date signed 10-28-43

Duration
10 YRS
LYR
2 DAYS
PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09526
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *630 W. Biddle St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *17*

(e) Length of stay in Baltimore (yrs., mos., or days) *3 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *630 W. Biddle St*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

David Williams

3 (b) If veteran, name war

3 (c) Social Security Account
No. *100-14-3810*

4. Sex

M

5. Color of race

col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ida

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *9-19-1891*

8. AGE: Years

52

Months

1

Days

37

If less than one day

hr.

min.

9. Birthplace *North Carolina*

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name *Fred Cooper*

13. Birthplace

N. C.

14. Maiden Name *Hannah?*

15. Birthplace

N. C.

16 (a) Informant *Ida Williams*

(b) Address *630 W. Biddle St*

17 (a) *Shipped* (b) Date thereof *10-25-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Brooklyn Cemetery*
Location *Nashville, N. C.*

18 (a) Funeral director *William A. Jackson*

(b) Address *Huntington Williams, Md.*

19 *OCT 27 1943* (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/26/1943* *3:20* M

21. I certify that death occurred on the date above stated; that I attended deceased from *10/16/1943* to *10/26/1943*, and that I last saw him alive on *10/25/1943*.

Immediate cause of death

*Cerebral Vascular
Due to Renal disease
Hypertension*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify transport place)

(e) Means of injury

23. Signature *W. A. Jackson*

Address *630 W. Biddle St*

Duration
10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09527
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Armistead Hotel

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Joseph Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account

No. *Widowed*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife *Catherine*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1893

8. AGE: Years Months Days If less than one day

50

hr. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Solomon Shapiro

13. Birthplace

Russia

14. Maiden Name

Rosa

15. Birthplace

Russia

16 (a) Informant *Mrs. Anna*

(b) Address

17 (a) *Burial* (b) Date thereof *10-23-43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Resdale

Location

Phil Rd + Hamilton St

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Balto St.

19 (a) *27 1943*

(Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Armistead Hotel*

Fayette + Holliday Sts (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 26* 1943, at *11:00* M

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in my

opinion resulted from: *natural causes* ☒ accident ☐ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH *chronic pulmonary*

tuerculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Robert Lee Graham* M.D.

Date signed *October 26, 1943*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09528

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 421 Laurens St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 421 Laurens St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Tyler Godfrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female Colored

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - 1904

8. AGE: Years 39 Months 1 Days - If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

12. Name William Tyler

13. Birthplace Md

14. Maiden Name Bessie Tyler

15. Birthplace Md

16 (a) Informant George Godfrey

(b) Address 421 Laurens St.

17 (a) Burial (b) Date thereof 10 29 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium St. Peter's Cemetery
Location Baltimore Md

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna ave

OCT 27 1943 (b) H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1943, at 12 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Date signed October 26, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09529
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 27 1943

(Date rec'd by registrar)

(b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 43 10/25 3:06 AM

21. I certify that death occurred on the date above stated that I attended deceased from 10/16 19 43 to 10/25 19 43 and that I last saw him alive on 10/25 19 43.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09530
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1310 Small St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

3 (a) FULL NAME

Joe, Turpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Col.

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Mary Turpin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 53 Months 9 Days 11 hr. min.9. Birthplace Denton, Md.
(town, county, and state)10. Usual Occupation Laborer

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial(b) Date thereof Oct 27-43

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1310 Small St.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 24 1943 2 P M21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1943 to Oct 24 1943and that I last saw him alive on Oct 24 1943

Immediate cause of death

Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

P. M. StalekAddress 1218 E. Pk St.Date signed 10/26/43

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 27 1943

Huntington, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09531
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security account No.

Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-43

8. AGE: Years Months Days If less than one day

2 23 hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Daniel Baynor

13. Birthplace Balto Md

14. Maiden Name Mildred Carroll

15. Birthplace Balto Md

16 (a) Informant Mildred Carroll

(b) Address 515 N. Bruce St

17 (a) Burial (b) Date thereof Oct 27-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem

Location

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams

Oct 27 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 515 Bruce St

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1943 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1943 to Oct 26 1943, and that I last saw her alive on Oct 26 1943.

Immediate cause of death

Non Specific Diarrhea

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. G. Bayfield

Address Providence Hosp Date signed 10/26/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09532

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1212 N. Stricker St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1212 N. Stricker St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

GLADYS BEVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 8, 1916

8. AGE:

Years

Months

Days

If less than one day

27

5

15

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Typist

11. Industry or business

FATHER

12. Name

John W. Bevans

13. Birthplace

Maryland

MOTHER

14. Maiden Name

Maud West

15. Birthplace

Maryland

16 (a) Informant

John W. Bevans

(b) Address

1212 N. Stricker St.

17 (a)

Burial

(b) Date thereof

10-27-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Anthony

Location

18 (a) Funeral director

Sam'l H. Chase Hon

(b) Address

638 N. Gilman St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943 at 6:10 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Interactions, pulmonary

Due to

Other Conditions

As

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wallerstein M.D.

Date signed 10-24-43

1001-27-1943 (b) Dr. J. H. Williams, M.D.

G 09533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09533

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1712 E. Biddle St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

3 (a) FULL NAME

Lillian L. Froelke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Caucasian

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Judge6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

October 17, 1895

8. AGE:

Years

Months

Days

If less than one day

48-7

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

12. Name

Red Downswell

13. Birthplace

Va.

14. Maiden Name

Ellen ?

15. Birthplace

Va.

16 (a) Informant

Judge Froelke

(b) Address

1712 E. Biddle St.17 (a) Burial

(b) Date thereof

Oct 27, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Calvary Cemetery

Location

A. G. County, Md.

18 (a) Funeral director

Mrs. Robert A. Elliott, Jr.

19 (a) Address

1129 N. Caroline St.(b) HuntingtonWilliamson, Md.

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1712 E. Biddle St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1943 at 12:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15, 1943 to Oct 27, 1943, and that I last saw him alive on 10/20, 1943.

Immediate cause of death

Chronic Nephritis

Duration

9 months

Due to

Due to

Other Conditions

Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Calvin B. LeCompteAddress 1113 N. Caroline St. Date signed 10/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

095343698

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1543 W. Woodyear St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore city
(If outside city or town limits, write RURAL and give town)(d) Street No. 1543 W. Woodyear St
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Frances Laura Borden Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Henry Richardson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Dec 18 1879

8. AGE: Years Months Days If less than one day
65 10 - 7 hr. min.9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business own home

12. Name Henry Whittington

13. Birthplace Calvert Co Md

14. Maiden Name Unknown

15. Birthplace Calvert Co

16 (a) Informant Mrs. Alice Fountain

(b) Address 830 7th St N.E. Washington D.C.

17 (a) Burial (b) Date thereof 10-27-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George B. Nelson

(b) Address 1303 Presetman St

19 OCT 27 1943

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1943 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3-1943 to 10-25-1943, and that I last saw her alive on 10-24-1943.

Immediate cause of death

Cerebral hemorrhage

Due to Nephritis + hypertension

Due to

Other Conditions Pulmonary pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank A. Saunders M. D.

Address 1024 N. Stuyvesant Date signed 10-25-43

Duration

4 days

Unknown

22 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09535

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2518 Greenmount Ave
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2518 Greenmount Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Rocco Di Benedetto

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married6 (b) Name of ~~XXXXXX~~ wife Gaetana Di Benedetto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23rd 1864

8. AGE: Years

79

Months

Days

2

If less than one day

hr.

min.

9. Birthplace Pratola Peligna Italy

(Town, county, and state)

10. Usual Occupation Medicine manufacturer

11. Industry or business

12. Name Giovanni Di Benedetto13. Birthplace Italy14. Maiden Name Rosaria Antonini15. Birthplace Italy16 (a) Informant John Di Benedetto (Son)(b) Address 2518 Greenmount Ave17 (a) Burial (b) Date thereof Oct. 28/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Holy RedeemerLocation Belair Rd.18 (a) Funeral director Frank Della Nore(b) Address 52 N. Morley St.19 (a) John Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1943 at 7 P M21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1943 to Oct. 25 1943, and that I last saw him alive on Oct. 24 1943.

Immediate cause of death

Cardio-Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature B. J. FatchewAddress 1775 ParkDate signed 10/24/43

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

THIS CERTIFICATE, WITH CHANGING INK, Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 27 1943

V8 3

09536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09536
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 N. Bay Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John H. Nash

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1922

8. AGE: Years Months Days If less than one day
2 1 5 6 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Pullman Porter

11. Industry or business

12. Name John H. Nash13. Birthplace Md.14. Maiden Name Josephine15. Birthplace Md.16 (a) Informant Margaret Commander(b) Address 2314 OK St. S.W. D.C.17 (a) Burial (b) Date thereof 10/27/42
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Int. Calvary
Location18 (a) Funeral director Elroy O. Wilson(b) Address 1033 S. E. Ave.(c) Huntington Hills, Md.

(d) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1942 at 12:5 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Crushed Head

Due to

Other Conditions Multiple fractures and locomotion

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10/24/42 at 11:25 P.M.(b) Where did injury occur? Fayette, at work(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No(d) Means of injury Red train struck by auto-truck23. Signature Howard J. Chalderis M.D.Date signed 10/25/42 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09537

CURRAN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09537

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Williams & Catons Aves.*

(c) Hospital or institution:

St. Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME*J. Matthew Curran*

3 (b) If veteran, name, war

3 (c) Social Security Account

No. *219-14-0832*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Wife - Christine*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *10-11-00*

8. AGE:

Years

Months

Days

If less than one day

*43**-**14*

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Personal Mgr.

11. Industry or business

12. Name

Edw. (deu.)

13. Birthplace

Md.

14. Maiden Name

Elizabeth Rodley

15. Birthplace

Md.

16 (a) Informant

Hoep Records

(b) Address

17 (a)

Burial

(b) Date thereof

Oct 28 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Agnes City

Location

Ellicott City, Md.

18 (a) Funeral director

Easton Sons

(b) Address

*Ellicott City, Md.***001 27 1943**

VS 160

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Howard

(c) City or town

Ellicott City

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Main St.

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION20. DATE OF DEATH *October 25 1943 1:15 P.M.*21. I certify that death occurred on the date above stated, that I attended deceased from *10/23 1943* to *10/25 1943*, and that I last saw him alive on *10/25 1943*.

Immediate cause of death

Cerebral haemorrhage

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

none

Major findings of operations

of autopsy?

none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Howard W. Stier

Address

*St. Agnes Hoep.*Date signed *10-24-43***PHYSICIAN**

Underline the cause to which death should be charged statistically.

09538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09538
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1536 N. Caroline St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. 1536 N. Caroline
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Margaret A. Hartman

3 (b) If veteran, name year

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

*Widowed*6 (b) Name of husband or wife *Phillips B.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Dec 23 - 1869*8. AGE: Years Months Days If less than one day
73 9 29 hr. min.9. Birthplace *Baltimore*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Alois J. Hartman*13. Birthplace *Germany*14. Maiden Name *Anna B. Welch*15. Birthplace *Germany*16 (a) Informant *Mrs. Seabold*(b) Address *1536 Caroline St.*17 (a) *Burial* (b) Date thereof *Oct 27 - 43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Holy Redeemer*
Location18 (a) Funeral director *Leonard J. Ruck*(b) Address *5305 Harford Road*(c) *Huntington Williams, MD*

OCT 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 22 1943* at *5:30* P.M.21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 1943* to *Oct 22 1943*, and that I last saw her live on *Oct 22 1943*.

Immediate cause of death

*Coronary Thrombosis*Due to *Arteriosclerotic Cardiovascular disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *W. W. H. Grenger*Address *1402 B. female St.* Date signed *Oct 23 1943*

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09539

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2703 Fleetwood Ave. Haml.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Fleetwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna M. Kurtz

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John George Kurtz
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) March 18, 1876

8. AGE: Years 67 Months 7 Days 7 If less than one day
min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Henry Hana

13. Birthplace Germany

14. Maiden Name Elizabeth Kreuder

15. Birthplace Germany

16 (a) Informant Mr. John G. Kurtz (Husband)

(b) Address 2703 Fleetwood Avenue

17 (a) Burial (b) Date thereof Oct. 26, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto., Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1725 Harford Avenue

19 OCT 27 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1943

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Aug 1 1943 to Oct 25 1943.
and that I last saw her alive on Oct 24 1943.

Immediate cause of death Asphyxia
Cirrhosis of Liver

Due to

Due to

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation Aug 14 43

Major findings of operation:
Cirrhosis of Liver
of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Dr. A. Anderson M. D.

Address 3001 Shannon Ave Date signed Oct 25-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09540

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 West 40th St.

(c) Hospital or institution:

Home for Incurables - 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 5 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

3 (a) FULL NAME

Helen Smith Stockbridge

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Henry Stockbridge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 25, 1857

8. AGE: Years Months Days

85

11

1

hr.

min.

9. Birthplace Hadley, Mass.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Chester Smith

13. Birthplace Hadley, Mass.

14. Maiden Name Mary Ann Warner

15. Birthplace Hadley, Mass.

16 (a) Informant H. L. R. Brown

(b) Address 700 W. 40th St.

17 (a) Burial (b) Date thereof Oct 28/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium London Park

Location 3801 Frederick Ave.

18 (a) Funeral director John O'Connell

(b) Address 1906 Eutaw Place

19 OCT 27 1943 (b) Thurston Williams

VS 2

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 700 West 40th St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1943, at 7:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1942, to October 26 1943, and that I last saw him alive on 10/25 1943.

Immediate cause of death

Coronary occlusion

Due to arteriosclerosis (hardened)

Due to Hypertension (high blood pressure)

Other Conditions Rheumatoid +
Hypertrophic Aortic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature W. M. H. Hargrave

Address 214 Medical Ct. Bk Date signed 10/27/43

Duration
minutes

20 yrs

15 yrs

15 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

Printed name of informant, with ONFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09541
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Md.
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FRANCES B. RINGSDORF

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1906

8. AGE: Years Months Days If less than one day
7 8 15 hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation School-girl

11. Industry or business

12. Name Joseph L. Ringsdorf

13. Birthplace Balto, Md.

14. Maiden Name Imelia C. Gzanoradz

15. Birthplace Balto, Md.

16 (a) Informant Joseph J. L. Ringsdorf

(b) Address 1204 N. Montford Ave

17 (a) Burial (b) Date thereof 10-26-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108-10 North Avenue

19 OCT 27 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

October 27, 1943 2:30 A.
19 at M

20. DATE OF DEATH

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Burns, 1st, second and third degree,
body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 10-26-43 at 6:50 P.M. 8/4
M.

(b) Where did injury occur? 1206 N. Montford Ave.

(c) Did injury occur at home, on farm, industrial place, in public
place? above address While at work? No

(d) Means of injury Burns, 1st, 2nd & third degree
or body clothing caught fire

23. Signature J. L. Wallenmeyer M.D.

Date signed 10-27-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09542

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5301 Beaufort Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 77

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Balto

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5301 Beaufort Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rennie L. Engler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Wm. E. Engler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1867

8. AGE: Years 76 Months 7 Days 4 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

12. Name Wm. Thomas Diven

13. Birthplace Scotland

14. Maiden Name Elizabeth McCoy

15. Birthplace Ireland

16 (a) Informant Mrs. Eva Hickey

(b) Address 5301 Beaufort Ave

17 (a) Burial (b) Date thereof 10-26-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md.

18 (a) Funeral director Loring Myers

(b) Address 5005 P St Apt 2

OCT 27 1943

Dr. William H. Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1943, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Oct 23 1943

and that I last saw him alive on 19

Immediate cause of death Talourar Heart Disease

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Samuel J. Hickey M. D.

Address 5611 Paulina Rd

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09543
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Henry Brown

13. Birthplace S. Carolina

14. Maiden Name Mary E. Jones

15. Birthplace Balto. Md.

16 (a) Informant Mary E. Jones

(b) Address 887 Boyd St. Street

17 (a) (b) Date thereof 10 25 43

(Burial, cremation, or removal)

(c) Cemetery or crematorium Mt. Calvary Cemetery

Location Balto.

18 (a) Funeral director Balto. B. Springs

(b) Address 139 W. Hamby St.

19 (a)

(Date rec'd by)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25

1943, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1943, to Oct 25 1943, and that I last saw her alive on Oct. 25 1943

Immediate cause of death

Malnutrition and Ischemia

Due to Diarrhea (Non infective)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

OCT 27 1943

G 09544

HEALTH DEPARTMENT—CITY OF BALTIMORE

G 09544

CERTIFICATE OF DEATH. 13✓927

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 707 N. Mount St. WARD 16)

2. FULL NAME

Emily Brooks Mayfield

(a) RESIDENCE NO.

207 N. Mount St.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced. (write the word)

Widow

6a If married, widowed, or divorced HUSBAND of or WIFE of

Henry Mayfield

6 DATE OF BIRTH (month, day, and year)

Oct. 25, 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

J. C.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Prince Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Sarah Aterbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant

Core Webb

(Address)

207 N. Mount St.

OCT. 27 1943

Huntington Williams, M.D.

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 25, 1942

17

I HEREBY CERTIFY, That I attended deceased from

1941 to Oct. 25, 1942

that I last saw her alive on Oct. 25, 1942

and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

Chl. Myocarditis
Chl. Valv. Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exam

(Signed) W. S. Taylor M. D.

19 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt Auburn Cemetery

DATE OF BURIAL

10-28-1943

20 UNDERTAKER

Mrs Geo H. Holland

ADDRESS

1631 Mount Hill Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

09545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09545

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hosp. Balto. Md. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Cauc

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

6 1/2 yr. min.

9. Birthplace 1112 Harlem Ave

(Town, county, and state) Balto. Md.

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 27 1943

18 (a) Funeral director

(b) Address

19

OCT 27 1943

VS 158

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(d) Street No. 1112 Harlem Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1943 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1943 to 10/24 1943 and that I last saw her alive on 10/21 1943.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature S. L. Smith

Address Univ Hosp Date signed 10/27/43

10471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09546
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Univ. Hospital, Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 5 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

Street No. 626 W. Montgomery St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

OCT 27 1943

(Date registered)

Huntington Williams, M.D.

Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1943 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1943, to 10/19 1943, and that I last saw him alive on 10/18 1943.

Immediate cause of death Delirium

Duration

Due to Nutritional

Due to

Other Conditions 2 clau

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

S. S. French, M.D. Date signed 10/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 159

G 09547
Registered No.

1. PLACE OF DEATH: *Franklin Square Hosp.*(a) *Baltimore City, Maryland*(b) Street address: *Calhoun & Fayette Sts*(c) Hospital or institution: *Franklin Square Hosp*(d) Length of stay in hospital or inst. (*years*, or days) *3 days*(e) Length of stay in Baltimore (*years*, *months*, or days) *3 days*3 (a) FULL NAME *Sheppard Forrest Jr.*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *M*5. Color or race *White*6 (a) *Single*, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *October 18, 1943*8. AGE: Years Months Days If less than one day
3 hr. min.9. Birthplace *Baltimore, Md*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Sheppard Forrest*13. Birthplace *Baltimore, Md*14. Maiden Name *Horn*15. Birthplace *Baltimore, Md*16 (a) Informant *Mother*

(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location *UNIVERSITY MEDICAL SCHOOL OCT 27 1943*18 (a) Funeral director *Commissioner of Health*

(b) Address

19 *OCT 27 1943* *Attending Physician*
(Date of death) (Signature of physician)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*(b) County *Baltimore*(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1928 Lemon St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/20/43* 19 *at 10:30 P. M.*21. I certify that death occurred on the date above stated; that I attended deceased from *10/18/43* 19 *10/20/43* 19
and that I last saw him alive on *10/20/43* 19

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: *Hydrocephalus*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Joseph B. Lankaster* M. D.Address *Franklin Square Hosp* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09548
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **400 N. Pulaski St.**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **400 N. Pulaski St.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Christina B. Perry

3 (b) If veteran, name war

3 (c) Social Security Account
No. **None**

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife **Francis W. Perry**

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) **Nov. 20, 1886**

8. AGE:

Years

Months

Days

If less than one day

56 yrs.

11

4

hr.

min.

9. Birthplace **Baltimore, Md.**

(Town, county, and state)

10. Usual Occupation **Owner of Grocery Store**

11. Industry or business

FATHER

12. Name **George A. Schmidt**

13. Birthplace **Baltimore, Md.**

MOTHER

14. Maiden Name **Theresa Hopf**

15. Birthplace **Baltimore, Md.**

16 (a) Informant **Francis W. Perry**

(b) Address **400 N. Pulaski St.**

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **Oct. 28/43**

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore City

18 (a) Funeral director

B. Vernon Lemmons

(b) Address **4611 Park Heights Ave.,**

19 (a)

(Date rec'd by registrar)

(b)

William M. Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 24 1943 at 11:25 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **6/24 1943** to **10/24 1943**, and that I last saw her alive on **10/24 1943**.

Immediate cause of death

**Coronary of Left
Pneum.**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **William M. Williams**

Address **400 N. Payson St.**

Date signed **10/24/43**

M. D.

OCT 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09549
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day,

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him live on

Immediate cause of death:

Due to

Due to

Other Conditions

(Include pregnancy within 1 month of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

442033
G 09550BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09550

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Broadway

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) 11⁰

(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County **City**(c) City or town **BALTIMORE**
(If outside city or town limits, write RURAL and give town)(d) Street No. **1518 LAKESIDE AVE**
(If rural give location)(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country3 (a) FULL NAME **MARIE Foley**3 (b) If veteran, name war
None3 (c) Social Security Account
No. **None**4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Widow**6 (b) Name of husband or wife **Frank D. Foley**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **12-22-88**8. AGE: Years **54** Months **10** Days **5** If less than one day
min.9. Birthplace **Md**
(Town, county, and state)10. Usual Occupation **None**

11. Industry or business

12. Name **Andrew Tumbleson**13. Birthplace **Md**14. Maiden Name **SARA E CARPENTER**15. Birthplace **Md**16 (a) Informant **Records**(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **OCT. 20, 1943**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **New Cathedral**
Location **Edmondson Ave. Balto; Md.**18 (a) Funeral director **George J. Ruth, Inc.**(b) Address **1745 Harford Ave****OCT 27 1943** (b) Registrar

VB 164

MEDICAL CERTIFICATION

20. DATE OF DEATH **OCT 27 1943** at **3:20 A** M21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 28 1943** to **OCT 27 1943**, and that I last saw him alive on **OCT 27 1943**.

Immediate cause of death

Pneumonia with respiratory failure

Due to

Due to

Other Conditions **Fracture, rt hip**

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide **Accident**(b) Date of occurrence **9-11-43** at **2** M(c) Where did injury occur? **Balto. Md.**
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? **hospital** While at work? **No**
(Specify type of place)(e) Means of injury **Falling** **Fall in chapel**23. Signature **William H. Shuck**Address **Johns Hopkins Hosp** Date signed **10/27/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Testimony of Physician by **Howard J. Madsen, M.D.**

G 09551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09551

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 3/470

3 (a) FULL NAME

HARRY J HACKETT

3 (b) If veteran, name war

3 (c) Social Security Account

No. 186-05-8816

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

ANNA HACKETT

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

8-17-07

8. AGE:

Years

Months

Days

If less than one day

36

2

9

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

Welder

11. Industry or business

Ship Yard

12. Name

WILLIAM HACKETT

13. Birthplace

Neb

14. Maiden Name

ANNA HIPKINS

15. Birthplace

Md

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Oct 30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St Ann's Cem.

Location

Baltimore Md

18 (a) Funeral director

E. J. Thompson

1000 N. Baltimore

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1821 E BALTIMORE

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26

1943

10:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1943, to Oct 26 1943, and that I last saw him alive on Oct 26 1943.

Immediate cause of death

Respiratory Failure

Duration

Due to

Pneumococcal Pneumonia

2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

confining

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

Means of injury

Blow from hammer

Address

344

Date signed

10-22-43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09552
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Howard + Madison*

(c) Hospital or institution:

Med. Gen. Hosp.(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 mos*(e) Length of stay in Baltimore (yrs., mos., or days) *4 mo*

3 (a) FULL NAME

Benjamin Wm. Behrens Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or divorced. *S*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 11-1943

8. AGE:

Years

Months

Days

If less than one day

*4**16*

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name *Benjamin Wm Behrens*

13. Birthplace

Baltimore

MOTHER

14. Maiden Name *Mary Miller*

15. Birthplace

Baltimore

16 (a) Informant

Mrs. Mary Behrens

(b) Address

*2125 E. Fairmount Ave*17 (a) *Burial*

(b) Date thereof

10 29 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Matthews

Location

Baltimore

18 (a) Funeral director

Philip Herwig Inc

(b) Address

2024 Orleans St

18 (a) Funeral director

Philip Herwig Inc

(b) Address

2024 Orleans St

OCT 28 1943

Huntington Williams

VB 110

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2125 E Fairmount av.*

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 27* 1943, at *4:10 P*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 27 1943* to *Oct 27 1943*, and that I last saw him alive on *Oct 27 1943*.

Immediate cause of death

*Infections
diarrhea*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Herman Williams*

M. D.

Address *Med. Gen. Hosp.* Date signed*Oct. 27, 1943*

correct age in especially important. Physicians: please write the cause of death clearly and legibly.

09553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09553
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (year, month, or days)

(e) Length of stay in Baltimore (year, month, or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 2202 Eutaw Pl.

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

Infant Fletcher

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

Male

5. Color or race

N

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10-24-93

8. AGE: Years Months Days

If less than one day

22 hr. 42 min.

9. Birthplace

Baltimore, Maryland

10. Usual Occupation

11. Industry or business

12. Name William Charles Fletcher

13. Birthplace Farmington, W. Va.

14. Maiden Name Frances Pickens

15. Birthplace Supton, Penn.

16 (a) Informant Mrs. William C. Fletcher

(b) Address 2202 Eutaw Place

17 (a) Burial (b) Date thereof 10-28-93

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Prophet Hill

Location

Towson

18 (a) Funeral director

Shivash Mowul, 108 North Ave.

(b) Address

OCT 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1993, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 10-27 1993

Immediate cause of death

Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. J. J. J.

Address Home Hospital

Date signed 10-28-93

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09554
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

Life

3 (a) FULL NAME

ARTHUR D. LAW HORN

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. NONE

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-5-43

8. AGE: Years

Months

Days

If less than one day

13 1/4

21

hr.

min.

9. Birthplace

Balto.

Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

WILLIAM LAW HORN

13. Birthplace

VA

14. Maiden Name

ANNIE FALLS

15. Birthplace

VA

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10/28/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Balto. Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1215 St. Paul St.

Huntington Williams, Md.

19 (a)

OCT 28 1943

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

206 S. CAREY

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26

1943

at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1943, to Oct 26 1943, and that I last saw him alive on Oct 26 1943.

Immediate cause of death

Myocardial infarction

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John S. Harris

Address

Johns Hopkins Hosp

Date signed

10/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDS RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09555

Registered No.

09555

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. none

4 Sex

5 Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 28 1943

(b) Huntington Millman

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 27

1943, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended

deceased from August 19 to Oct 27 1943.

and that I last saw him alive on

19

Immediate cause of death

Chronic myocarditis

Due to

Due to

Other Conditions

Chronic passive liver congestion

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09556
JL - 82513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09356

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **4940 Eastern Ave.**
(c) Hospital or institution: **Baltimore City Hospitals**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **2, 4 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County
(c) City or town **Baltimore** (If outside city or town limits, write RURAL and give town)
(d) Street No. **2207 York Ave.** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Marjorie Brooks

3 (b) If veteran, name war No. 3 (c) Social Security Account No. **none**

4. Sex **F** 5. Color or race **W.** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Emmett Brooks**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 2, 1899**

8. AGE: Years **44** Months **5** Days **25** 4 hr. min.

9. Birthplace **Md.** (Town, county, and state)

10. Usual Occupation **Unemployed (Laborer)**

11. Industry or business **Wt. Vernon Mills**

12. Name **John Hubbard**

13. Birthplace **Va.**

14. Maiden Name **Margaret Tacey**

15. Birthplace **Md.**

16 (a) Informant **B. C. H. Records**

(b) Address **4940 Eastern Ave.**

17 (a) **Burial** (b) Date thereof **10/30/43**
(Burial, cremation, or other disposal) (month) (day) (year)

(c) Cemetery as designated **St. Marys**
Location **Hampton (Baltimore, Md.)**

18 (a) Funeral director **William Cook Inc.**

(b) Address **1217 St. Paul**
OCT 28 1943 (Date rec'd by registrar) (b) **Huntington Williams, M.D.** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **10-26** 19**43** at **9:30 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **7-9** 19**43** to **10-26** 19**43**, and that I last saw him alive on **10-26** 19**43**

Immediate cause of death

Carcinoma of Cervix
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **Jaune**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Dorinda A. Stubb** M. D.
Address **Baltimore City Hosp** Date signed **10-27-43**

Duration

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09557

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street Address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *9-0-4*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *603 Pierce Street*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Myrtle Travers (State)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

36

hr. min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Domestic

12. Name *Lavi Travers*

13. Birthplace *Md.*

14. Maiden Name *Carrie Johnson*

15. Birthplace *Md.*

16 (a) Informant *Mrs. Carrie Washington*

(b) Address *1805 W. Franklin St.*

17 (a) *Burial* (b) Date thereof *Oct. 29, 1943*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Trinity Calvary*

Location *Trinity*

18 (a) Funeral director *Adolphus Hight*

(b) Address *918 Dundas Street*

Oct 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-24-1943* at *10¹² P.M.*

21. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *her* death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐

homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Shock

Due to *15-20 degree burns*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury *10-24-43* at *9:15 P.M.*

(b) Where did injury occur? *603 Pierce Street*

(c) Did injury occur at home, on farm, industrial place, in public

place? *Home* While at work? *No*

(d) Means of injury *Confusion*

23. Signature *Howard G. Anderson* M.D.

Date signed *7/25/43*

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDS RESERVED FOR BINDING

G 09558

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09558

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, give RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased on

and that I last saw deceased on

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G 09559

BALTIMORE CITY HEALTH DEPARTMENT

✓ G 09559

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 1914 W. Franklin st.
- (c) Hospital or institution: 20
- (d) Length of stay in hospital or inst. (yrs., mos., or days) no
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1914 W. Franklin st.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Lillian I. Hillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

7

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 27-1866

8. AGE:

Years

Months

Days

If less than one day

761128

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Retired

FATHER

12. Name

George Stewart

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden Name

Laura E. Sayes

15. Birthplace

Baltimore, Md.

16 (a) Informant

Lillian Hillman

(b) Address

1914 W. Franklin st.

17 (a)

Burial

(b) Date thereof

10/29/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London NationalLocation on top of husband

18 (a) Funeral director

Charles F. Jones

(b) Address

2427 Edmondson ave

19 (a)

OCT 28 1943

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 25, 1943 at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1943 to 10/25 1943, and that I last saw her alive on 10/25 1943.

Immediate cause of death

Arteriosclerotic Cardio-vascular disease

Due to

Due to

Other Conditions

Chronic HypertensionArteriosclerotic Cardio-vascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edmondson

M. D.

Address 402 N. Paiper St.Date signed 10/26/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09560

G 09560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94w

1. PLACE OF DEATH

CITY OF BALTIMORE: *3007 Garrison Ave*

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If foreign birth? yrs. mos. da.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

Ward.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX *M* 4. Color or Race *Or* 5. Single, Married, Widowed, or Divorced (write the word) *Married*

6a. If married, name of spouse (or) name of deceased

*Ann K. Isaac*6. DATE OF BIRTH *April 16-1873*7. AGE Years Months Days If LESS than 1 day, hrs. or min. *70 7 11*8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. *Blat*9. Industry or business in which work was done, as city mill, saw mill, bank, etc. *Municipal Bldg*

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) *Wiltshire, Pa*13. NAME *Herman Isaac*14. BIRTHPLACE (city or town) (State or country) *?*15. MAIDEN NAME *?*16. BIRTHPLACE (city or town) (State or country) *?*17. INFORMATION *Mrs. Joe H. Isaac*(Address) *3007 Garrison Ave*18. BURIAL, CREMATION, OR REMOVAL *Ches. Shalom Cem. 10/29/43*19. UNDERTAKER *W. H. Brown Co*(Address) *3003 Vicksburg Rd*

OCT 28 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) *Oct 27* 19*43*22. I HEREBY CERTIFY, That I attended deceased from *Jan 1* 19*43* to *Oct 27* 19*43*last saw him alive on *Oct 26* 19*43* Death is said to have occurred on the date stated above, at *m.*

The principal cause of death and related causes of importance were as follows:

Coronary Embolism

Date of onset

*1 day*Other contributing causes of importance: *Arterio Sclerosis*

Was an operation performed? Date of

For the disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury. 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *Howard J. Marud* M. D.(Address) *4604 Garrison Blvd*

9561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written in correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mo., or days)
(e) Length of stay in Baltimore (yrs., mo., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1804 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Frieda Latham

3 (b) If veteran, name war 3 (c) Social Security Account No. —

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Earl F Latham 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Mar 2 - 1897

8. AGE: Years 46 Months 7 Days 23 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name William Burger

13. Birthplace Germany

14. Maiden Name Margaret

15. Birthplace Germany

16 (a) Informant Earl F Latham

(b) Address 1804 Rutland Ave

17 (a) Burial (b) Date thereof 10-28-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Immanuel

Location Trindon Lane

18 (a) Funeral director Wendell C Humphreys

(b) Address 1801 N. Broadway

OCT 28 1943 (b) —

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1943 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 9 1943 to OCT 25 1943, and that I last saw him alive on 19

Immediate cause of death PULMONARY EMBOLISM

Due to THROMBOSIS PHLEBITIS, LEFT INTRACAVITY

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury W. Hoffman M.D.

23. Signature W. Hoffman M.D.

Address 8 East Park St Date signed 10/27/43

Duration
x
165005
PHYSICIAN
Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09562**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *30 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *30 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *N. Y.* (b) County

(c) City or town *Little Falls*
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Miss. Frances J. Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. *Married*

6 (b) Name of husband or wife *Dr. Elton Tate*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 17, 1886*

8. AGE: Years

57

Months

6

Days

10

If less than one day

hr.

min.

9. Birthplace *New York*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business *Own home*

12. Name *Hallie M. Hale*

13. Birthplace *New York*

14. Maiden Name *Adeline Patterson*

15. Birthplace *New York*

16 (a) Informant *Dr. Elton Tate*

(b) Address *Little Falls, N. Y.*

17 (a) *Burial* (b) Date thereof *10/28/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium

Location *Elizabethtown, N. Y.*

18 (a) Funeral director *Wm. J. Thompson*

(b) Address *North 4th Ave.*

19 (a) *28-1942* (b) *Huntington, N. Y.*

(Date of death) (Place of death)

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 27* 19 *43*, at *11* *40* *PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 28* 19 *43* to *Oct 27* 19 *43*, and that I last saw her alive on *Oct 27* 19 *43*.

Immediate cause of death

Coronary occlusion

Due to *Myocardial heart disease*

Due to *Hypertension*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *10-27-43*

Major findings of operations

Hypertension

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Isabella Harrison*

Address *Church Home Hospital* Date signed *10-27-43*

Duration

1 min

3 mos

1 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09563
10-84831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09563
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Helen Gambrill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1873

8. AGE: Years 90 Months 9 Days 10 If less than one day hr min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John M. Dulaney (D)

13. Birthplace Maryland

14. Maiden Name Emily C. Higginbotham (D)

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Oct 29/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Location London

18 (a) Funeral director Henry H. Jenkins & Sons

(b) Address 700 Calverton Road

19 (a) (b) (Date rec'd by registrar)

Huntington Williams, M.D.

OCT 28 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 27 1943 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1943 to 10-27-1943, and that I last saw him alive on 10-27-1943.

Immediate cause of death

Cerebral Arteriosclerosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

Means of injury

23. Signature Paul Mott

Address BCH

Date signed 10/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09564
Registered No.

131B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPHINE V. SHRIVER

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Widow

6 (b) Name of husband or wife Edwin W. Shriver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1872

8. AGE: Years Months Days If less than one day
70 10 25 hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name -- Vacheron

13. Birthplace France

14. Maiden Name Susette ?

15. Birthplace Switzerland

16 (a) Informant Mr. Edwin P. Shriver

(b) Address Md. Yacht Club

17 (a) Burial (b) Date thereof 10/29/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westminster Cem.
Location, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1943, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 22, 1942, to Oct. 26, 1943, and that I last saw her alive on Oct. 25, 1943.

Immediate cause of death

Uraemic coma -
Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James E. A. Schumaker M. D.
Address 4912 Parklight Dr Date signed 10-28-43

Duration
48 hrs

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 28 1943
VS 100
Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09565
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 713 Winans Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Winans Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

H. Thompson Lang

3 (b) If veteran, name war
World War #1

3 (c) Social Security Account
No. 705-12-1140

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Dorothy Collison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1897

8. AGE: Years Months Days If less than one day
46 8 14 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Commercial Agent

11. Industry or business Canton Rd.

FATHER 12. Name John L. Lang

13. Birthplace Maryland

MOTHER 14. Maiden Name Emily Theise

15. Birthplace Maryland

16 (a) Informant Mrs. Dorothy O. Lang

(b) Address 713 Winans Way

17 (a) Burial (b) Date thereof 10/29/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location South Woodlawn, Md.

18 (a) Funeral director Wm. J. Dickner

(b) Address 2000 E. Baltimore St.

19 (a) OCT 28 1943
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1943, at 5:30 A. M.

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. X. Wallenrocher M.D.

Date signed 10-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09566

1. PLACE OF DEATH:
(a) City or town Baltimore
(b) Street address 632 N. Gilmore Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Gilmore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD HARRISON PINDLE

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Violet Pindle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1888

8. AGE: Years 55 Months 8 Days 10 If less than one day hr. min.

9. Birthplace Galesville, Md.
(Town, county, and state)

10. Usual Occupation Mail Carrier

11. Industry or business

12. Name Edward Pindle

13. Birthplace Md.

14. Maiden Name Martha Boston

15. Birthplace Md.

16 (a) Informant Mrs Violet Pindle

(b) Address 632 N. Gilmore St.

17 (a) Burial (b) Date thereof 10-30-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) OCT 28 1943 (b)

VR 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, '43 19 43 at 2:30 A

21. I certify that death occurred on the date above stated, that I attended deceased from 7/8/1943 to 10/27/1943 and that I last saw him alive on 10/26/1943

Immediate cause of death

Chronic Hypertension Duration 24 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John H. Harris

Address 1450 W. Biddle St. Balt. Md. 10/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09567
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 546 West Biddle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 West Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ELLA L FRAZIER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race Colored 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1878

8. AGE: Years 65 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John Saunders

13. Birthplace Vs.

14. Maiden Name Lee Nixon

15. Birthplace Va.

16 (a) Informant Mr. Thomas Frazier

(b) Address 1514 W. Lexington St.

17 (a) Burial (b) Date thereof 10-28-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) Date rec'd by registrar 10/28/43
Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, '43 19 at 6:45M

21. I certify that death occurred on the date above stated; that I attended deceased from 20/1943 to 10/25/1943 and that I last saw her alive on 10/25/1943

Immediate cause of death

Carcinoma of Stomach 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. Williams, M.D. 10/27/43
Address 458 W. Biddle St. Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09568

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 26

1943

at 5:16 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-1943 to 10-26-1943, and that I last saw him alive on 10-26-1943.

Immediate cause of death

Coronary Thrombosis.

Due to

Due to

Other Conditions

Cholera typhoid

(Include pregnancy within 3 months of death)

Date of operation

10-15-43

Major findings of operation:

Cholera typhoid

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles D. Marshall

Address 1413 Light St

Date signed 10-26-43

OCT 28 1943

G 09569

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09569

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *918 Hanover St*
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

*KATHERINE**FAHEY*

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

*W*6 (a) Single, married, widowed, or
divorced*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug. 30 1898*8. AGE: Years Months Days If less than one day
*45 1 26 hr. min.*9. Birthplace *Balto., Md.*
(Town, county, and state)10. Usual Occupation *Coast guard*

11. Industry or business

12. Name *George Sydings*13. Birthplace *Balto., Md.*14. Maiden Name *Jane McDowell*15. Birthplace *Balto., Md.*16 (a) Informant *Mr. Sydings (niece)*(b) Address *1289 Mallin St.*17 (a) *Burial* (b) Date thereof *Oct 30 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Cathedral*
Location *4300 Old Frederick St.*18 (a) Funeral director *McL. Loughly Funeral Home*(b) Address *1306 E. Fort Ave*19 (a) *Oct 28 1943* (b) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 26 1943* at *4:35 PM*21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to *his* death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *10-26-43* M.(b) Where did injury occur? *at home*(c) Did injury occur at home, on farm, industrial place, in public
place? *home* While at work? ☐(d) Means of injury *blow from gas stove*23. Signature *H. Z. Williams* M.D.
Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09570

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME George Savigich
3 (b) If veteran, name war
3 (c) Social Security Account No. 162093164

4. Sex Male
5. Color or race white
6 (a) Single, married, widowed, or divorced?
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895
8. AGE: Years 48 Months Days If less than one day hr. min.

9. Birthplace Yugoslavia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Fairfield Shipyard

12. Name
13. Birthplace Yugoslavia
14. Maiden Name
15. Birthplace Yugoslavia

16 (a) Informant Josie Cerdas
(b) Address Steelton Pa

17 (a) Burial (b) Date thereof Oct 28/43
(c) Cemetery or crematorium Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W. O. Zagarski
(b) Address 1930 Eastern Ave

19 (a) OCT 28 1943 (b) Registrar
Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct 26 1943 at 11:50 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1943, to Oct 26 1943, and that I last saw him alive on Oct 25 1943

Immediate cause of death Right Lobar Pneumonia
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury
23. Signature Samuel A. Hrubstein
Address 212 S. Broadway Date signed 10/27/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 0957
Registered No.

Registered No.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County _____
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Ashburton St
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

William E Frank

- MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 26 1948, at 2 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from October 26, 1948, and that I last saw him alive on October 26 1948.

- | | |
|-----------------------------|----------|
| Immediate cause of death | Duration |
| Coronary Thrombosis - acute | |

- Due to _____
- Due to _____

- Other Conditions _____

- (Include pregnancy within 8 months of death)
- Date of operation _____
- Major findings of operation: _____
- of autopsy: _____
- PHYSICIAN**
- Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- | (b) Date of occurrence | at | M |
|------------------------|----|---|
|------------------------|----|---|

- (c) Where did injury occur? _____

- (City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public

- place? _____ While at work? _____

- (Specify type of place)

- (e) Means of injury 1544

- W. H. Mendenhall*

2. Signature W. J. [illegible]

- Adm. 1914-20. North Platte, Neb. 10/3/43

- Address 2 1000 1st St. N.W. Date signed 1/1/71

- Laurel to Howard J. Malden

- 2017/01/10/10:00

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09572
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 432 S. Bonsal St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

Male White

5. Color of race

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Eva E.

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

65 7 10

March 17 1878

8. AGE:

Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

16 (b) Address

17 (a)

17 (b) Date thereof

17 (c) Cemetery or crematory

17 (d) Location

18 (a) Funeral director

18 (b) Address

19 (a) Date of death

19 (b) Date of death

19 (c) Date of death

19 (d) Date of death

19 (e) Date of death

19 (f) Date of death

19 (g) Date of death

19 (h) Date of death

19 (i) Date of death

19 (j) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(f) Date of death

(g) Date of death

(h) Date of death

(i) Date of death

(j) Date of death

(k) Date of death

(l) Date of death

(m) Date of death

(n) Date of death

(o) Date of death

(p) Date of death

(q) Date of death

(r) Date of death

(s) Date of death

(t) Date of death

(u) Date of death

(v) Date of death

(w) Date of death

(x) Date of death

(y) Date of death

(z) Date of death

(aa) Date of death

(ab) Date of death

(ac) Date of death

(ad) Date of death

(ae) Date of death

(af) Date of death

(ag) Date of death

(ah) Date of death

(ai) Date of death

(aj) Date of death

(ak) Date of death

(al) Date of death

(am) Date of death

(an) Date of death

(ao) Date of death

(ap) Date of death

(aq) Date of death

(ar) Date of death

(as) Date of death

(at) Date of death

(au) Date of death

(av) Date of death

(aw) Date of death

(ax) Date of death

(ay) Date of death

(az) Date of death

MEDICAL CERTIFICATION

DATE OF DEATH

Oct 27 1943 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1942 to Oct 27 1943, and that I last saw him live on Oct 27 1943

Immediate cause of death

Carcinoma of lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

2739 Eastern Ave

10/27/43

10/27/43

10/27/43

10/27/43

10/27/43

10/27/43

10/27/43

10/27/43

10/27/43

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10/27/43

10/27/43

10/27/43

10/27/43

G 09573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09573
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1203 W. Payette St.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME

Dr. Henry C. Ohle

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife

Mamie Bliss Canon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6/4/80

8. AGE: Years Months Days If less than one day
83 4 23 hr min.

9. Birthplace

Catonsville, Md.

(Town, county, and state)

10. Usual Occupation

Physician

11. Industry or business

12. Name Himrich Ohle
13. Birthplace Germany14. Maiden Name Pauline K. Peters
15. Birthplace Germany16 (a) Informant Mrs. Marie Ohle Mead
(b) Address 1203 W. Payette St.17 (a) Burial (b) Date thereof 10/30/43
(Burial, cremation, or removal) (month) (day) (year)
Loudon Park Cemy.(c) Cemetery or crematory
Location Fred. Ave. Balto. Md.18 (a) Funeral director J. J. Mitchell & Sons Inc.
(b) Address 1900 Butaw Place19 (a) (b)
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore,

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1203 W. Payette St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 19 43, at M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct 17 1943 to Oct 27 19 43
and that I last saw him alive on Oct 27 19 43

Immediate cause of death

Chronic myocarditis

Duration

?

Due to

Terminal bronchopneumonia 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Walter E. Humphrey

Address 1013 Payson Drive

M. D. 1
Date signed Oct 28 1943

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 28 1943

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

0574

AB- 83744

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09574
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 16
Baltimore City Hospitals(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME Benjamin Moore

3 (b) If veteran, name war
3 (c) Social Security Account No.4. Sex M
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Separated6 (b) Name of husband or wife Nina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1859

8. AGE: Years 84 Months 9 Days 10 If less than one day hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alex
13. Birthplace Md.
MOTHER
14. Maiden Name Maria Turner
15. Birthplace Va.16 (a) Informant Baltimore City Hospitals
(b) Address Records17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 28 1943

18 (a) Funeral director Commissioner of Health

19 (a) OCT 28 1943
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1943 at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9:00 1943 to 10-18 1943, and that I last saw him alive on 10-18 1943.

Immediate cause of death

Sphygmocardi arrest
fibrillary & decompensation
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mattman
Address BCHA Date signed 10/20/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09575

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09575

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2610 Roselawn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Roselawn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George B. Raver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Kate A.

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.)

Aug 19-1880

8. AGE:

Years

Months

Days

If less than one day

63

2

9

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Brakeman B & O RR

11. Industry or business

FATHER

12. Name

John Raver

13. Birthplace

Baltimore County

MOTHER

14. Maiden Name

Sophia Beeching

15. Birthplace

Baltimore

16 (a) Informant

Mrs. Katie Raver

(b) Address

2610 Roselawn Ave.

17 (a)

Burial

(b) Date thereof

10/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodland Memorial

Location

18 (a) Funeral director

Leonard J. Koch

(b) Address

1141 Ford Rd.

19 (a)

OCT 28 1943

(b)

Huntington Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 28 1943 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to October 1943, and that I last saw him alive on October 28 1943.

Immediate cause of death

Carcinoma of Lung

Duration

5 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

L. Harrell Pierce

Address

312 Med. Arts Bldg

Date signed

M.D.

10/28/43

Baltimore, md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6 09576
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2907 Jefferson St.
(If rural give location)

(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Elizabeth Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

N

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Bayezani Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 64 Months 4 Days 11 hr. min.
If less than one day

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name Robert Crane

13. Birthplace Baltimore

14. Maiden Name Catherine Barry

15. Birthplace Ireland

16 (a) Informant Vincent Talbert

(b) Address

17 (a) Burial (b) Date thereof 10/1/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Maryland

18 (a) Funeral director Leonard J. Cook

(b) Address 5305 Harbor Road

19 (a) OCT 28 1943

VB 140

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1943, to 10-28 1943, and that I last saw him alive on 10-28 1943.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive vascular disease
Arteriosclerosis

Due to Diabetic mellitus
Insulin

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William E. Cherd

Address St. Joseph's Hospital Date signed 10-28-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in pencil. Physicians: please write the causes of death clearly and legibly.

G 09577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09577
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1721 Covington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) about 27 yrs.

3 (a) FULL NAME

Barbara W. Whittington

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Robert Whittington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1872

8. AGE: Years Months Days If less than one day

70 10 9 hr. min.

9. Birthplace Prince George's Co., Md.

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

12. Name Thomas J. Ball

13. Birthplace Md.

14. Maiden Name Ellen (?)

15. Birthplace Md.

16 (a) Informant Clarence R. Whittington (son)

(b) Address St. Margaret's R.F.D. # 2

Annapolis, Md.

17 (a) Burial (b) Date thereof Oct. 30, 1943

(c) Cemetery or crematory Green Haven Cem.

Location G. A. Co., Md.

18 (a) Funeral director G. Howard Evans

(b) Address 400 N. Charles St.

19 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

OCT 28 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 1721 Covington St.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1943

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5, 1943 to 10-27, 1943

and that I last saw him alive on 10-26, 1943

Immediate cause of death

Chronic Myocardial Degeneration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

as called

Address 707 E. Fort Ave. Date signed 10-28-43

Duration

2y +

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09578	
CERTIFICATE OF DEATH		Registered No.	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland		(a) State <u>Md</u> (b) County	
(b) Street address <u>1716 N. Montford Ave</u>		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution:		(d) Street No. <u>1716 N. Montford Ave</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days)		(e) Citizen of foreign country? (Yes or No)	
(e) Length of stay in Baltimore (yrs., mos., or days)		If yes, name country	
3 (a) FULL NAME <u>George W. Schminker</u>			
3 (b) If veteran, name war <u>no</u>		3 (c) Social Security Account No. <u>220-03-0386</u>	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>Single</u>	
6 (b) Name of husband or wife			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Mar 27, 1905</u>			
8. AGE: Years <u>38</u>	Months <u>7</u>	Days <u>01</u>	If less than one day hr. min.
9. Birthplace <u>Baltimore Md.</u> (Town, county, and state)			
10. Usual Occupation <u>Watchman</u>			
11. Industry or business <u>H. S. Merchant Marine</u>			
12. Name <u>Henry P. Schminker Sr</u>			
13. Birthplace <u>Baltimore Md.</u>			
14. Maiden Name <u>Anna Schillinger</u>			
15. Birthplace <u>Baltimore Md.</u>			
16 (a) Informant <u>Henry P. Schminker Jr</u>			
(b) Address <u>1716 N. Montford Ave.</u>			
17 (a) <u>Burial</u> (b) Date thereof <u>Oct 30, 1943</u> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <u>Schwartz</u> Location <u>O'Donnell St.</u>			
18 (a) Funeral director <u>Mrs. John W. Timpf, Son</u>			
(b) Address <u>801 W. Fayette St.</u>			
19 (a) by registrar (b) Registrar <u>Huntington Williams</u>			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Oct 28, 1943, 3:15 A.M.</u>			
21. I certify that death occurred on the date above stated; that I attended deceased from <u>10-20-1943</u> to <u>10-28-1943</u> and that I last saw him alive on <u>10-27-1943</u> .			
Immediate cause of death			
<u>Chronic Valvular Heart Disease</u> <u>30 yrs</u>			
Due to <u>Rheumatic Fever</u> <u>30 yrs</u>			
Due to			
Other Conditions <u>Broncho pneumonia</u> <u>7 days</u>			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)			
(e) Means of injury			
23. Signature <u>Thelton C. Pang</u> M. D.			
Address <u>2117 Belair Rd</u> Date signed			

OCT 28 1943

10-28-43

09579
443460BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09579
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

(FULL NAME) ~~ROSINA~~ Rose Efford

(b) If veteran, name war

3 (c) Social Security Account

No. 212-09-8215

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or

divorced. WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-76

8. AGE: Years Months Days If less than one day

67 0 15 hr. min.

9. Birthplace

Md
(Town, county, and state)

10. Usual Occupation MACHINE OPERATOR

11. Industry or business Umbrella factory

12. Name ANDREW FISHER

13. Birthplace Germany

14. Maiden Name EVA

15. Birthplace GERMANY

16 (a) Informant RECORDS

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 29/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Philip Henry Lee

(b) Address 2024 Orleans St

OCT 20 1943 (Date of death) (Day) (Month) (Year)

Huntington Williams, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 970 N Collington Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1943, 915 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943, to Oct 26 1943, and that I last saw her alive on Oct 26 1943.

Immediate cause of death

Subarachnoid hemorrhage

Duration

24 hrs.

Due to Hypertensive cardio-

vascular disease

?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul O. Chatfield

Address Johns Hopkins Hosp. Date signed 10/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09580

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2-204

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 Eastern Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1892

8. AGE: Years Months Days If less than one day

51 0 27 21 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Odd jobs

11. Industry or business

12. Name Cornelius Dougherty

13. Birthplace Newark, N.J.

14. Maiden Name Margaret Kolan

15. Birthplace Lexington, Ken.

16 (a) Informant John J. Dougherty

(b) Address 1117 Breunelwood Ave

17 (a) Burial (b) Date thereof 10-30-43

(c) Cemetery or crematory Ball's Blk. Cem

Location Baltimore Md

18 (a) Funeral director Dunwood D. Opera Co

(b) Address 24 W. 25th St

(c) Telephone Williams, Md

19 (a) Date rec'd by registrar Oct 29 1943

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1943 8 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 25 1943 8 1 1/2 P M

(b) Where did injury occur? President & Pratt St

(c) Did injury occur at home, on farm, industrial place, in public

place? street While at work? No

(d) Means of injury Struck by trailer truck

23. Signature Robert L. Graham M.D.

Date signed Oct. 26 1943

9581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3801 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

LYDIA JEANETTE DORSEY

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1871

8. AGE: Years 72 Months 9 Days 8
If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Edward H. Appleby
13. Birthplace Baltimore, Md.

14. Maiden Name Annie M. Lamb
15. Birthplace Md.

16 (a) Informant Mr. Robert L. Dorsey
(b) Address 3801 Clifton Ave.

17 (a) Burial (b) Date thereof 10/29/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

001-29 1943

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1943, 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1942, to Oct. 26 1943, and that I last saw her alive on Oct. 26 1943.

Immediate cause of death

1 - Pericardium of heart.
Due to metastasis to lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1942

Major findings of operation: Pericardium of heart.
of autopsy - done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl E. Chambers
Address 408 Liberty St. Date signed 10/28/43 M.D.

Duration

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

09582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09582
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp.

(c) Hospital or institution:

Bon Secours Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 353 Yale Ave. (Yale Ave.)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John Lawrence Niner (Niner)

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. --

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Daisy V. Niner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1878

8. AGE: Years Months Days If less than one day

64

11

3

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Printing Supplies

11. Industry or business Self

12. Name John Niner

13. Birthplace Md.

14. Maiden Name Alice Van Sant

15. Birthplace Md.

16 (a) Informant Mrs. Daisy Niner

(b) Address 353 Yale Ave.

17 (a) Burial (b) Date thereof 10/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Com.

Location Frederick, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19. Date of death 29 1943

Date of registration

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1943 5 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1943 to 10/27 1943, and that I last saw him alive on 10/27/43.

Immediate cause of death

Coronary Vascular Collapse

Due to

Coronary Artery (?)

Due to

Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles P. Crumey

Address

Bon Secours Hosp.

Date signed

10/27/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09583

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1919 Brewster Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Brewster Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Michael J. Sommerlender

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 6 1873

8. AGE: Years

Months

Days

If less than one day

70120

hr.

min.

9. Birthplace

Balta

(Town, county, and state)

10. Usual Occupation Cabinet

11. Industry or business

FATHER
MOTHER

12. Name

Michael

13. Birthplace

Germany

14. Maiden Name

Mary Horstcher

15. Birthplace

Germany

16 (a) Informant

Mary C. Deems

(b) Address

1919 Brewster Ave17 (a) Burial(b) Date thereof 10/29-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Western

Location

Edmondson St

18 (a) Funeral director

Edward Fowler

(b) Address

2309 Wash Blvd19 (a) 29 1943(b) Huntington Williams, M.D.

(Each ruled by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26

19

at 11:30 M

21. I certify that death occurred on the date above stated; that I attended

deceased from Oct 22 1943 to Oct 26 1943and that I last saw him alive on Oct 26 1943

Immediate cause of death

ExpirationDue to RespiratoryDue to Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. J. CampbellAddress 1644 DanversDate signed 10/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09584

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a)

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematorium

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4, 1943, to Oct. 27, 1943, and that I last saw her alive on Oct. 27, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

10-28-43

G 09585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09585
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address:

(c) Hospital or institution:

Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2226 East Jefferson Street

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John Eliason

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1887

8. AGE: Years Months Days If less than one day

56 5 17 hr. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Ship Rigger

11. Industry or business

M & Dry Dock

FATHER
MOTHER

12. Name James E. Eliason

13. Birthplace Baltimore

14. Maiden Name Dorothy Langville

15. Birthplace Baltimore

16 (a) Informant James E. Eliason

(b) Address 2328 E. Madison

17 (a) Burial (b) Date thereof Oct 30

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location

City

18 (a) Funeral director William F. Funder House

(b) Address 2004-8. Orleans St

OCT 29 1943 (b)

Registrar

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 28 - 1943, 8:55 AM

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions Fractured femur, multiple
lacerations, abrasions - breast bones
(Include pregnancy within 3 months of death)22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury 10-27-43, 8:35 P M

(b) Where did injury occur Patterson Pl. near Dr. Elderly St

(c) Did injury occur at home, on farm, industrial place, in public
place? Public While at work? No

(d) Means of injury Pedestrian, struck by Auto-Truck.

23. Signature Thomas J. Maldeis M.D.

Medical Examiner.

Date signed 10-28-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age - - - years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

78

hr.

min.

9. Birthplace Missouri

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Sands Bouton

13. Birthplace New York State

14. Maiden Name Mary Jane Perry

15. Birthplace Virginia

16 (a) Informant Ivan M. Marty

(b) Address Butler, Maryland

17 (a) Burial

(b) Date thereof 10/29/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. John's

Location Butler, Maryland

18 (a) Funeral director

(b) Address

805 N. Calvert Street

OCT 29 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. Western Run Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 27

1943, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1943, to Oct 27 1943,

and that I last saw him alive on Oct 27 1943

Immediate cause of death

Respiratory Failure

Due to

Cardiovascular

Due to

dissect

Other Conditions

Possible Meningococcemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

10/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09587
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton St
(c) Hospital or institution:
N. M. Carroll Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ARTHUR SNOWDEN

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 10, 1857

8. AGE:

Years 86

Months 5

Days 18

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant Mrs. Rosa Stewart

(b) Address 822 N. Carrollton Av.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 10-30-43

(month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Mrs. Frances A. Hemsley

18 (a) Funeral director 578 W. Biddle St.

(b) Address

19 (a)

Witnessed by registrar

(b)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct, 28, '43 19 at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1943, to Oct. 28, 1943, and that I last saw him alive on Oct. 28, 1943.

Immediate cause of death

Uremia

Duration

1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Raely W. Reckling
Address 426 N. Glenn St
Date signed 10/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 29 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09588

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1740 Lancaster Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Lancaster St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Stanislaw Slowikowski

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-07-1967

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mary Slowikowski

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 18 78

8. AGE:

Years

Months

Days

If less than one day

65

5

hr.

min.

9. Birthplace Poland

(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

Southern Pkg Co.

FATHER

12. Name

John Slowikowski

13. Birthplace

Poland

MOTHER

14. Maiden Name

Maryanna ?

15. Birthplace

Poland

16 (a) Informant Mrs. Mary Slowikowski

(b) Address 1740 Lancaster Street

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

11-2-43

(month) (day) (year)

(c) Cemetery or crematory

St. Stanislaus

Location

Baltimore Md

18 (a) Funeral director

George A Weber

(b) Address

705 S. Ann street

19

Dr. J. H. Williams

1802 Eastern Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29th 1943, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1940 until Oct. 29 1943, and that I last saw him alive on Oct. 29 1943

Immediate cause of death

1. Hemiplegia

Duration

4 days

Due to Hypertension

3 yrs

Due to Arterio-sclerosis

3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John K. Seitz

M. D.

Address

1802 Eastern Ave

Date signed

10-27-43

09589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09589

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address: Monument St. Rutland Ave
 (c) Hospital or institution: Sinai Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 2
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Md. (b) County
 (c) City or town: Balt.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.: 4413 Pimlico Rd.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Hattie Arpsman

3 (b) If veteran, name war

3 (c) Social Security Account No.

- 4 Sex: Female
 5. Color or race: White
 6 (a) Single, married, widowed, or divorced: Married
 6 (b) Name of husband or wife: Roy Arpsman
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1891
 8. AGE: Years: 72 Months: Days: If less than one day hr. min.

9. Birthplace: Poland
 (Town, county, and state)

10. Usual Occupation: Housewife
 11. Industry or business

12. Name: -
 13. Birthplace: Poland

14. Maiden Name: -
 15. Birthplace: Poland

- 16 (a) Informant: Roy Arpsman
 (b) Address: 4413 Pimlico Rd.

- 17 (a) Burial
 (Burial, cremation, or removal)
 (b) Date thereof: 10-29-43
 (month) (day) (year)
 (c) Cemetery or crematory: Woodlawn

- Location: -
 18 (a) Funeral director: Joseph Reine Inc
 (b) Address: 1429 S. Balt. St.

- 19 (a) Date of death: OCT 28 1943
 (b) Signature: Huntington Williams, M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1943 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1943 to Oct 28 1943, and that I last saw him alive on Oct 27 1943.

Immediate cause of death:

Uremia
 Due to Congestive HT failure

Due to Hypertension

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Robert H. Jacobs, M.D.
 Address: Sinai Hospital Date signed: 12/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05590

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 05590

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4600 Park Heights Ave

(c) Hospital or institution:

Mt Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO

(If outside city or town limits, write FULL and give town)

(d) Street No. 4613 Park Heights Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

REBECCA SAPERSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

MORRIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

66

If less than one day

hr.

min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Max Saperstein

13. Birthplace

Russia

14. Maiden Name

Mollie

15. Birthplace

Russia

16 (a) Informant

Morris Saperstein

(b) Address

17 (a)

Burial

(b) Date thereof 10-24-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Windsor Hill Rd

Location

Windsor Hill Rd

18 (a) Funeral director

Jant Lewis Inc

(b) Address

1439 E. Paul St

DCT 29 1943

Huntington Williams

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28-43 19 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1943 to Oct 28 1943, and that I last saw him alive on Oct 28 1943.

Immediate cause of death

Cardio-renal vascular disease

Duration

3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2128 W. North St

Date signed 10/28/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDS - RESERVED FOR FINDING

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09591**

09591

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7 days**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County

(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)

(d) Street No. **1944 Druid Hill Ave**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
30 9 17 hr. min.

9. Birthplace **Lancaster, Va.**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 29 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 27 1943** at **7:30 PM**

21. I certify that death occurred on the date above stated, that I attended deceased from **Oct 20 1943** to **Oct 27 1943** and that I last saw her alive on **Oct 27 1943**

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed **10/28/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

99592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09592
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Date of death)

(Place of death)

20

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.F.D. and give town)

(d) Street No.

(If positive location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 28 - 1943 at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1943 to Oct. 28 1943 and that I last saw her alive on Oct. 27 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09593

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2024 Madison Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

2.

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof Oct. 29, 1943

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

OCT 29 1943

(Date of death)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-27

1943 at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1943 to 10-27-1943 and that I last saw him alive on 10-27-1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

M. D.

Address 805 N. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

490 G 09594

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3605 Brooklyn Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Bernice Lamar Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

7

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Gartha

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

Feb 16, 1903

8. AGE:

Years

Months

Days

If less than one day

40

8

13

hr.

min.

9. Birthplace

Bedford Va

(Town, county, and state)

10. Usual Occupation

Housework

11. Industry or business

12. Name

Thomas C. Hepinstall

13. Birthplace

Bedford Va

14. Maiden Name

Effie Bernard

15. Birthplace

Franklin County Va

16 (a) Informant

Mary Light

(b) Address

25 Tisbury Dundalk

17 (a)

Burial

(b) Date thereof

Oct 31 1943

(c) Cemetery or crematory

Gladehill

Location

Virginia

18 (a) Funeral director

20 Wm Cork Inc

(b) Address

1217 St Paul Balto

19 (a)

20 1943

Thurston Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Va

(b) County

Franklin

(c) City or town

Gladehill

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 29 1943 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1943 to 10/29 1943 and that I last saw her alive on 10/29 1943.

Immediate cause of death

Toxicity from abdominal carcinoma

Due to

Origin ovary

Due to

Other Conditions sigmoidal

obstruction (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Samuel Rubin

M. D.

Address

203 Calapan

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09595

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Funeral

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26 1943, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1943, to Oct 26 1943, and that I last saw him alive on Oct 26 1943.

Immediate cause of death

Carcinoma of Left Lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09596

Registered No.

46 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1620 Bowlegs Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1620 Bowlegs Lane

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Nicholas Bione

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Annie Bione

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

2 2 1882

8. AGE:

Years

Months

Days

If less than one day

61

2

2

hr.

min.

9. Birthplace

Sicily - Italy

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

Self

FATHER
MOTHER

12. Name

Unknown Bione

13. Birthplace

"

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant

Annie Bione

(b) Address

1620 Bowlegs Lane

17 (a)

Burial

(b) Date thereof

10/30/43

(Burial, cremation, or other)

(month), (day) (year)

(c) Cemetery or place of interment

Holy Redeemer

Location

Balto. MD

18 (a) Funeral director

W. J. [unclear]

(b) Address

1217 St. Paul. Balto.

1939 1943

Huntington Williams, MD

(Date recorded registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to Oct 28 1943 and that I last saw him alive on Oct 28 1943

Immediate cause of death Chronic myocardial failure

Duration

Due to Toxemia

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify name of place)

(e) Means of injury

23. Signature

W. J. [unclear] MD

Address

Balto 6

Date signed

10/28/43

G 09597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09597

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5409 Knell Ave

(c) Hospital or institution:

At Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

3 (a) FULL NAME

Mary Magdalena Conklin

3 (b) If veteran, name war

No

3 (c) Social Security Account

No

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

William A Conklin6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.)

Feb. 23, 1897

8. AGE: Years

46 yrs

Months

8 mo

Days

4

If less than one day

hr. min.9. Birthplace Northport Long Island N.Y.

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

at home

FATHER

12. Name

John Latta

13. Birthplace

Germany

MOTHER

14. Maiden Name

Caroline Kirsch

15. Birthplace

Germany

16 (a) Informant

William A Conklin

(b) Address

5409 Knell Ave

17 (a)

Burial

(b) Date thereof

Oct. 30/43

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

Genoa Cemetery

Location

Northport Long Island N.Y.

18 (a) Funeral director

James W. Conklin

(b) Address

924 E. Laver St.

OCT 29 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County

(c) City or town

Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5409 Knell Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1943 at 4 p M21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1943, to Oct 27 1943 and that I last saw him alive on 19

Immediate cause of death

Acute cardiac dilatationDue to Ch MyocarditisDue to Ch Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation noMajor findings of operation: —

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. L. HornsteinAddress 733 Argenith StDate signed 10/28/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09598

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Abel Sansone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1943

8. AGE: Years Months Days If less than one day
10 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Marcus Sansone

13. Birthplace Baltimore Md

14. Maiden Name Lillian Hart

15. Birthplace Baltimore Md.

16 (a) Informant Marcus Sansone

(b) Address 1720 Johnson St.

17 (a) Burial (b) Date thereof Oct. 29-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. G. Co.

18 (a) Funeral director Elizabeth Harle Inc.

(b) Address 115 E. J. West St.

(c) Date of death Oct 29 1943

(d) Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1720 Johnson St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1943 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1943 to Oct. 28 1943, and that I last saw him alive on Oct. 28 1943.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul H. Lukate

Address 213 Light St. Date signed 10/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09599
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 YR.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6208 SHIPVIEW WAY DUNDALK

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NON E

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

FEMALE

WHITE

WIDOW

6 (b) Name of husband or wife SAMUEL A. MOTLEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 5 1871

8. AGE: Years Months Days If less than one day

72

9

22

hr.

min.

9. Birthplace VIRGINIA

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JAMES DULANEY

13. Birthplace VA.

14. Maiden Name ELLA SMITH

15. Birthplace VA.

16 (a) Informant SAMUEL MOTLEY (SON)

(b) Address 6208 SHIPVIEW WAY DUN.

17 (a) BURIAL (b) Date thereof OCT. 30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory CEDAR HILL

Location BLADENSBURG MD.

18 (a) Funeral director Lilly and Geiler, INC.

(b) Address 403 S. WOLFE ST.

19 (a) OCT 29 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1943, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1943, to Oct. 27 1943, and that I last saw her alive on Oct. 27 1943.

Immediate cause of death

Respiratory Failure

Due to

Cerebro vascular

Due to

Hemorrhage. Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature David W. Morgan

Address University Hosp. Date signed 10/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09600
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6308 MARIETTA AVE.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Gilbert F. ADELHARDT Jr.

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

m.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 21 1940

8. AGE: Years Months Days If less than one day
2 11 6 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

12. Name GILBERT ADELHARDT

13. Birthplace BALTO. MD.

14. Maiden Name EILEEN KERNER

15. Birthplace BALTO. MD.

16 (a) Informant GILBERT ADELHARDT. (FATHER)

(b) Address 6308 MARIETTA AVE.

17 (a) BURIAL (b) Date thereof OCT. 30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST.

19 (a) OCT. 29 1943 Registrar William M. P.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1943. at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1942. to Oct. 27 1943. and that I last saw him alive on Oct. 27 1943.

Immediate cause of death Myocardial infarction complicated by glomerulonephritis.
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul G. Zukats

Address 1213 Light St. Date signed 10/27/43

Duration
13 days
2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 09601
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 815 Madison Ave
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Minnie Elizabeth Dew

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W.6 (a) Single, married, widowed, or
divorced.Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Sept. 27-1888

8. AGE:

Years

Months

Days

If less than one day

5511

hr.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Charles Kesting

13. Birthplace

Germany

14. Maiden Name

Pauline Loeffert

15. Birthplace

Baltimore Md

16 (a) Informant

Pauline Kesting

(b) Address

815 Madison Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Oct. 30/48
(month) (day) (year)

(c) Cemetery or crematory

Western Cemetery

Location

Baltimore Md

18 (a) Funeral director

Chas E Frank

(b) Address

502 Madison Ave
Thurgood Marshall Bldg, Md

19 (a)

(b)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.

815 Madison Ave
(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 28 1948 at 5 P.M.21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage
spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature

Robert L. Frank

M.D.

Date signed

Oct. 29

Medical Examiner

1948

Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09602

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1413 Light St.

(c) Hospital or institution:

South Baltimore Jail Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md

(b) County:

(c) City or town: Balto, Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1201 Hanover

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country:

3 (a) FULL NAME

NOUVEY J. ENZENGA

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4 Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

Female white

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 23 - 1932

8. AGE:

Years

Months

Days

If less than one day

10

10

5

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

School Girl

FATHER
MOTHER

12. Name

Anthony J. Enzenga

13. Birthplace

Baltimore Md.

14. Maiden Name

Wendy M. Nalls

15. Birthplace

Ja

16 (a) Informant

Anthony J. Enzenga

(b) Address

1701 S. Hanover St.

17 (a)

Burial

(b) Date thereof

11-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Balto, Md.

18 (a) Funeral director

Flynn & Fleming

(b) Address

1426 Light St.

19 (a)

(b)

OCT 29 1943

Huntington, N.Y.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 28 1943 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1943 to Oct 28 1943, and that I last saw her alive on Oct 28 1943.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. F. Hawtanner

Address

18 Randall St.

Date signed

10/28/43

Duration

6 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

09603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09603
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2807 Mosher St
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 7 weeks, 16
 (e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County
 (c) City or town Balto MD
 (If outside city or town limits, write RURAL and give name)
 (d) Street No. 2807 Mosher St
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

William C. Schroder

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. yes

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mary M. Schroder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug-9-1919

8. AGE: Years

64

Months

12

Days

14

If less than one day

hr. min.

9. Birthplace

Balto MD

(Town, county, and state)

10. Usual Occupation

Lithographer

11. Industry or business

Falconer & Co

FATHER

12. Name

Francis H. Schroder

MOTHER

13. Birthplace

Balto MD

14. Maiden Name

Sarah Demmon

15. Birthplace

Balto MD

16 (a) Informant

Wm E. Mary M. Schroder

(b) Address

2807 Mosher St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 30-43

(c) Cemetery or crematory

Neurothedral

Location

Balto, MD

18 (a) Funeral director

H. B. Manning Son

(b) Address

2924 Edmonds Dr

(c) Date of death

Oct 29 1943

(d) Cause of death

Heart failure

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 27 1943 at 11 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from

Oct 2 1943 to Oct 27 1943

and that I last saw him alive on

Oct 26 1943

Immediate cause of death

Arachnoiditis with

cord compression

Due to with paraplegia

Due to

Other Conditions

(Include pregnancy within months of death)

Date of operation

July 26-1943

Major findings of operation

No stone

of autopsy: not done

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

John L. G. [Signature]

Address 1219 [Address]

Date signed 10/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09604

Registered No.

45F

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga Sts*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *14 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *3rd* (b) County *Baltimore*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *4301 Ph 7th Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Frederick D. Wiencke (FREDERICK D. WIENCKE.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. *M*

6 (b) Name of husband or wife *Mathewina*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 23, 1891*

8. AGE: Years Months Days If less than one day
72 0 4 hr. min.

9. Birthplace *Baltimore, Md*
(Town, county, and state)

10. Usual Occupation *Retired*

11. Industry or business

12. Name *Frederick Wiencke*

13. Birthplace *Germany*

14. Maiden Name *Catherine Wagner*

15. Birthplace *Germany*

16 (a) Informant *Mary H. Becker*

(b) Address

17 (a) *Burial* (b) Date thereof *10/30/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Pruid Ridge*

Location *Balto. Co.*

18 (a) Funeral director *C. L. L. L. L.*

(b) Address *4611 Ph 11 St*

19 (a) (b) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 27 1943, at 6:15 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 13 1942* to *Oct 27 1943*, and that I last saw him alive on *Oct 27 1943*.

Immediate cause of death *Granuloma*

Duration

Due to *Carcinoma of Pharynx*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Biospy*

Major findings of operation: *Squamous cell Carcinoma of Pharynx*
of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Henry F. Ziegler*

Address *Mercy Hospital*

Date signed *10/27/43*

OCT-29 1943

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09605

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 04

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1014 Peach St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

John

Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1884

8. AGE:

Years

Months

Days

If less than one day

59

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 29 1943

Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a)

OCT 29 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1943, at 11 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Evans M.D.

Date signed October 1 1943

09606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09606
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1007 Duffin Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Henry A. Kew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

55

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 29 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 29 1943

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/9

1943, 11, 10 P.M.

21. I certify that I took charge of the remains described above, held an
F 7555-004 thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to natural death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary-vascular Reveal Disease (H.J.M.)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Hugh B. Mcnelly, M.D.

Date signed

10/10/43

Medical Examiner.

10475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09607
AB-83703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09607
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 26 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 120 S. Bond St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Blanche Elizabeth McCready

Or Blanche Elizabeth Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hobart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-1897

8. AGE: Years Months Days If less than one day
46 5 6 hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John Taylor (D)

13. Birthplace ?

14. Maiden Name Mary ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) Burial (b) Date thereof Nov. 2, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Washington, D.C.

18 (a) Funeral director Mrs. George W. Holland

(b) Address 1631 Duff Hill Ave.

19 (a) (b) Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1943 at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1943 to 10-28 1943, and that I last saw her alive on 10/28 1943.

Immediate cause of death

Azotemic

Due to Nephrosclerosis

Directly by hypertensive cardiac vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Melina

Address B. C. 14

Date signed 10/29/43

Duration

1 mo

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 29 1943

G 09608

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09608
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 313 E. Lanvale

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Patricia Ann

McCartney

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. ROSE

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 19, 1942

8. AGE:

Years

Months

Days

If less than one day

1

5

109

min.

9. Birthplace

Grafton

N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

Glynn E. McCartney

13. Birthplace

Grafton

N.C.

14. Maiden Name

Mabel

Stutler

15. Birthplace

Grafton

N.C.

16 (a) Informant

Glynn E. McCartney

(b) Address

313 E. Lanvale St

17 (a) Removal

Funeral

(b) Date thereof

10/28/43

(c) Cemetery or crematory

Mt. Pleasant

Location

Mt. Pleasant, Towson, Md.

18 (a) Funeral director

William H. Jones

(b) Address

1217 S. Paul St

19 (a) Date of death

Oct. 29, 1943

(b) Registered by

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1943, at 8 P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Pulmonary edemaDue to Swallowing kerosene

Other Conditions

(Include pregnancy within 2 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Oct. 28 1943, at 12 P. M.(b) Where did injury occur? 313 E. Lanvale St

(c) Did injury occur at home, on farm, industrial place, in public

place? Home While at work? No(d) Means of injury Swallowed kerosene23. Signature Robert C. Graham, M.D.Date signed Oct. 29 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09609

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09609
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 769 W. Cross St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Dorothy L. Lutz

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 19, 1892

8. AGE: Years Months Days If less than one day

51 4 89 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Koppers Co.

12. Name Edward Lutz

13. Birthplace Baltimore Md.

14. Maiden Name Katie B. Stevens

15. Birthplace Baltimore Md.

16 (a) Informant Dorothy L. Lutz

(b) Address 769 W. Cross St.

17 (a) Burial (b) Date thereof Nov. 1, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Ave

18 (a) Funeral director Rev. John W. Gimpel, Son

(b) Address 801 W. Fayette St.

19 (a) 29 1943

(b) for

(c) for

(d) for

(e) for

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 769 W. Cross St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1943 to Oct 28 1943, and that I last saw him alive on Oct 28 1943

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Coronary disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Warren Wachter M. D.

Address 422 Md. St. Bldg. Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 29 1943

154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09610

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09610

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: *Lombard & Greene*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *4-2*
(e) Length of stay in Baltimore (yrs., mos., or days) *8*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Alb.*
(c) City or town *Jessup*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2* (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harriett Fields

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Frank H. Fields

6 (c) If alive, give age

72 years

7. Birth date of deceased (mo., day, yr.)

March 17 1877

8. AGE: Years

66

Months

7

Days

9

If less than one day

hr.

min.

9. Birthplace

Maryland

(City, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Lackland Higgins

13. Birthplace

MD

14. Maiden Name

Augusta Hammond

15. Birthplace

MD

16 (a) Informant

Frank H. Fields

(b) Address

Jessup MD

17 (a)

Burial

(b) Date thereof *Oct 30-43*

(c) Cemetery or crematory

Baldwin Memorial

Location

Lambert Hill

18 (a) Funeral director

Lloyd Kassar

(b) Address

Laurel MD

OCT 30 1943

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/28* 1943, at *9:30* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *10/20* 1943, to *10/28* 1943, and that I last saw h.e.r. alive on *10/28* 1943.

Immediate cause of death

Acute lymphatic leukemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *none*

Major findings of operations

of autopsy: *acute lymphatic leukemia*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Josephine E. Renshaw

M. D.

Address *Univ. Hospital*

Date signed *10/28*

09611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09611
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0.9.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 704 S. Port St.

(If rural give location)

(e) Citizen of foreign country? NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

FRANCIS PATRICK MCADAMS

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 212-09-1845

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Lena Schmidt

McAdams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1877

8. AGE:

Years 65

Months 10

Days 7

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Gibbs Preserving Co.

12. Name ? McAdams

13. Birthplace Maryland

14. Maiden Name Unknown

15. Birthplace Maryland

16 (a) Informant Mr. Lester McAdams

(b) Address 704 S. Port St.

17 (a) Burial (b) Date thereof 10/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore County, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1648 E. North Ave.

OCT 30 1943 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1943. 2:45 P.M.

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert C. Luthin M.D.

Date signed Oct. 27 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09612

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1400 - N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 days

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(d) Street No. 717 S. Port St
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY BOY WAWRZYNIAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
1 11 11 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof Oct 30 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. O. Z. Z. Z.

19 OCT 30 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 29 1943, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 18 1943, to 10 - 29 1943, and that I last saw him alive on 10 - 29 1943.

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Bellina

M. D.

Address St. Joseph's Hosp Date signed

10/29/43

09613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

G 09613 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Redwood & Green*

(c) Hospital or institution:

Univ. Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*(b) County *Balt*

(c) City or town

Bald -

(If outside city or town limits, write RURAL and give town)

(d) Street No. *313* *Tombbridge Rd.*

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

David Worth Stonecliffe

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Oct 26 - 1943*

8. AGE: Years Months Days If less than one day

3

hr.

min.

9. Birthplace *Balt. Md.*

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name *David Worth Stonecliffe*13. Birthplace *Baltimore Harbor, Md.*14. Maiden Name *Dorothy Bonetall*15. Birthplace *Schofield Bk. Th. of Hawaii*16 (a) Informant *Mrs. Dorothy Stonecliffe*(b) Address *313 Tombbridge Rd.*17 (a) (b) Date thereof *10/30/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Baltimore*Location *Fennell Road*18 (a) Funeral director *Walter Brooks Bradley*(b) Address *1922 21st St. N.W. Wash. D.C.**Huntington Williams, M.D.**OCT 30 1943*

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH *10 - 29 1943* at *9 P M*21. I certify that death occurred on the date above stated; that I attended deceased from *10-26 1943* to *10-29 1943* and that I last saw him alive on *10-29 1943*.Immediate cause of death *Hemorrhagic disease of new-born*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Dean S. Davis M.D.*Address *University Hosp* Date signed *10/29/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09614

JL - 83471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09614
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

3 (a) FULL NAME

Dotson, Elle Mae

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
F

5. Color or race
C

6 (a) Single, married, widowed, or
divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1924

8. AGE: Years Months Days If less than one day
19 5 28 hr min.

9. Birthplace S. C.

(Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business 1214 Balto., St.

12. Name James Dotson

13. Birthplace S. C.

14. Maiden Name Hettie Davis

15. Birthplace S. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov 2, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County,

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton Ave.

19 (a) Date of death Oct 30 1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1729 W. Lanvale St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1943 at 4:57 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 8-26 1943 to 10-28 1943.
and that I last saw her alive on 10-28 1943.

Immediate cause of death

Due to Hodgkin disease 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mattone M.D.

Address BC 4 Date signed 10/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09615

CHIPMAN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09615

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5 Color or race

6 (a) Single, married, widowed, or

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

OCT 30 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended

deceased from 10/18 1943 to 10/28 1943.

and that I last saw him alive on 10/28 1943.

Immediate cause of death

Coronary Thrombosis

Due to

Arterio sclerotic Cordis
vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

Address 7600 York Rd. Zone 12

Date signed 10/29/43

M. D.

09616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09616

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address U.M.H.

(c) Hospital or institution:

Union Memorial Hosp 27-13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (Roland Park)
(If outside city or town limits, write RURAL, and give town)(d) Street No. 310 Edgevale Road
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Dr. Dewitt Talmadge Hunter

3 (b) If veteran, name war

Great War & this war

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Teresa Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 1890

8. AGE: Years Months Days If less than one day

53

2

1

hr.

min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual Occupation Retired Commander U.S. Navy

11. Industry or business Med officer U.S. NAVY

12. Name Smiley Hunter

13. Birthplace North Carolina

14. Maiden Name Elizabeth Mathews

15. Birthplace North

16 (a) Informant wife Mrs. Dewitt J. Hunter

(b) Address 310 Edgevale Road Roland Park

17 (a) Removal (b) Date thereof Oct 30 43

(c) Cemetery or crematory Arlington National

Location Arlington Va.

18 (a) Funeral director Henry H. Hunter & Sons

(b) Address McCulloch & Orchard St

(c) Date rec'd by registrar Oct 30 1943

(d) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1943, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1943, to Oct 28 1943, and that I last saw him alive on Oct 28 1943.

Immediate cause of death

Coronary thrombosis

Due to Myocarditis

Due to Hypertensive Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address 1115 St Paul St

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09617

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 115 Longwood Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Robert B. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife Hester Corner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 18988. AGE: Years 45 Months 2 Days 8 If less than one day hr. min.9. Birthplace Balto. Md.
(Town, county, and state)10. Usual Occupation Grocery

11. Industry or business

12. Name Harry M. Wagner13. Birthplace Balto. Md.14. Maiden Name Harriet C. Van Sant15. Birthplace N. D.16 (a) Informant Mr. H. Milton Wagner(b) Address Ruxton, Md.17 (a) Burial (b) Date thereof Oct. 30, 1943
(Burial, cremation, or removal) (month, day, year)(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.18 (a) Funeral director John O. Mitchell(b) Address 1900 Eutaw Place19 (a) OCT 30 1943 (b) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Longwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1943 6:15 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from September 1, 1943 to Oct 28, 1943, and that I last saw him alive on Oct 28, 1943.

Immediate cause of death

Coronary arteriosclerosis 3 yrs.
Coronary occlusion 9 mos.
Due to embolism pericarditis
" to ureteral stone
Due to BanOther Conditions General arteriosclerosis 3 yrs

(Include pregnancy within 3 months of death)

Date of operation noneMajor findings of operations: noneof autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. S. ClappAddress 6210 York Rd. Date signed Oct 29 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09618

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09618

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4208 Main Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Main Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Anna F. Falck

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Widowed

6 (b) Name of husband or wife William C. Falck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1860

8. AGE: Years Months Days If less than one day

83

5

28

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

12. Name Frank Fenzel

13. Birthplace Germany

14. Maiden Name

15. Birthplace

16 (a) Informant Veronica Fenzel

(b) Address 4208 Main Ave.

17 (a) Burial (b) Date thereof 10/ 29/ 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore.

18 (a) Funeral director Martin Fahey & Sons

(b) Address 1827 W. North Ave.

OCT 30 1943
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 26 / 43, at M

21. I certify that death occurred on the date above stated; that I attended
deceased from 1940 1942 to 1946 1948
and that I last saw him alive on 1943 1943

Immediate cause of death Tuberculosis
and myocarditis

Due to Prof. Arch. Substantia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. Urban Smith M.D.

Address 517 West 6th St. Date signed 10/28/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in pencil. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09619

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 808 W Bane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-1

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

3 (a) FULL NAME

William P Blatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Ida A. Blatt

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 19/1886

8. AGE: Years 57 Months 5 Days 10 hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business B & O R.R.

12. Name Peter Blatt

13. Birthplace Germany

14. Maiden Name Charlotte Freyer

15. Birthplace Germany

16 (a) Informant Mrs Ida A Blatt

(b) Address 808 W. Bane St

17 (a) Burial, cremation, or removal (b) Date thereof 11/1/1943

(c) Cemetery or crematory Mt Olivet Cem

Location 2930 Federal Rd

18 (a) Funeral director John J. Cowan & Son

(b) Address 901 S. Hollis St

19 (a) Date of death OCT 30 1943

(b) Place of death Huntington Hall, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 808 W. Bane (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1943 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1943 to Oct 29 1943, and that I last saw him alive on Oct 29 1943.

Immediate cause of death Cerebral hemorrhage due to hypertension

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. H. Max Murchey M. D. Address 779 E. Chase Date signed 10/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09620

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Monument & Rutland*

(c) Hospital or institution:

Simai Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 days*(e) Length of stay in Baltimore (yrs., mos., or days) *55 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Lake Drive Apt.*(e) Citizen of foreign country *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

—

3 (c) Social Security Account

No. *None*

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

Widow

6 (b) Name of husband or wife

—

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) *May 25, 1864*

8. AGE: Years Months Days Less than one day

79 45 3 hr. min.9. Birthplace *England*

(Town, county, and state)

10. Usual Occupation *None*

11. Industry or business

12. Name *Simon Nathan*13. Birthplace *England*14. Maiden Name *Unknown*15. Birthplace *England*16 (a) Informant *Mr. Philip S. Perlman*(b) Address *Lake Drive Apt.*17 (a) *Burial* (b) Date thereof *10/31/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Chet Shalom*Location *Balti. Md.*18 (a) Funeral director *David Soudan*(b) Address *1902 Eutaw Place*Date of death *Oct 30 1943*Registrar *Huntington Williams*

VS 120

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 28, 1943. 2:10 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 20, 1943. to Oct. 28, 1943.* and that I last saw her alive on *Oct. 28, 1943.*Immediate cause of death *Cardiac**Failure*Due to *Coronary Thrombosis*Due to *Atherosclerotic C.P.D.*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Henry Muesnick*Address *Simai Hosp.* Date signed *10/30/43*

Duration

*8**days*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09621

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

421 N. Pine St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Baltimore

(d) Street No.

(If outside city or town limits, write RURAL and give town)

421 N. Pine St.

(e) Citizen of foreign country?

(If rural give location)

no

(Yes or No)

If yes, name country

3 (a) FULL NAME

Adam A. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

m

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Olivia Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 16, 1893

8. AGE: Years

Months

Days

If less than one day

50

07

12

hr.

min.

9. Birthplace

Baltimore md.

(Town, county, and state)

10. Usual Occupation

Bookkeeper

11. Industry or business

FATHER

12. Name

Thomas Brown

13. Birthplace

MOTHER

14. Maiden Name

Alie Berryman

15. Birthplace

md.

16 (a) Informant

Bertha Payne

(b) Address

1216 Mosher St.

17 (a)

Burial

(b) Date thereof

Nov 1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

mt. Auburn

Location

18 (a) Funeral director

James A. Hayes

(b) Address

142 N. Hill St.

19

OCT 30 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 28 1943, 2:25 AM

21. I certify that death occurred on the date above stated that I attended deceased from Oct. 24 1943 to Oct. 28 1943 and that I last saw him alive on Oct. 27 1943

Immediate cause of death

Myocarditis

Due to

Influenza

Due to

Other Conditions none

(Include pregnancy within 5 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

John W. Spines

Address

645 W. Camden

Date signed

10/29

(City or town) (County) (State)

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

(Specify type of place)

While at work?

Duration

3 days

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09622
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2405 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HARRY CURTIS TAYLOR

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Mollie Buck Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1877

8. AGE: Years Months Days If less than one day
65 10 14 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home Furnishings

11. Industry or business Own (retired 8 yrs)

12. Name Henry Clay Taylor

13. Birthplace Balto

14. Maiden Name Laura Allen

15. Birthplace Balto.

16 (a) Informant Mrs. Mollie B. Taylor

(b) Address 2405 W. Lanvale St.

17 (a) Burial (b) Date thereof 10/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1943 at 6:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to Oct 28 1943, and that I last saw him alive on Oct 27 1943.

Immediate cause of death

Totemia

Due to Trophic ulcers

Due to Tuberculous

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. P. Von Schupmann M. D.
Address 1818 Edmondson Ave Date signed Oct 29, 1943

Duration
2 wks

4 wks

8 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

VB 110
OCT 20 1943

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09523

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert and Sanctuary*

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *36 years*

3 (a) FULL NAME

Mr. Walter P. George

3 (b) If veteran, name war

3 (c) Social Security Account
No. 213 - 01 - 0872

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mrs. Helen George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 23, 1893

8. AGE:

Years

Months

Days

If less than one day

50

2

5

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

Bookkeeper (Shipping Clerk)

11. Industry or business

Goldfish Atlantic Fish Co.

12. Name

Mr. George

13. Birthplace

Maryland

14. Maiden Name

E. Stille Patterson

15. Birthplace

Maryland

16 (a) Informant

Record

(b) Address

Mercy Hospital

17 (a) Burial

(b) Date thereof

11/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral Cem.

Location

Balto., Md.

18 (a) Funeral director

Wm. J. Tickner & Sons

(b) Address

Balto., Md.

19 *Oct 30 1943*

(b)

Huntington Williams

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Balto.

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

4203 Valley View Ave.

(If rural, give location)

(e) Citizen of foreign country?

No.

(Yes or No)

If yes, name country

-

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 21 1943 at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 25 1943* to *Oct 28 1943*, and that I last saw him alive on *Oct 28 1943*.

Immediate cause of death

Myocardial - Renal Failure

Due to

Malignant Hypertension

Due to

Under Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

Ferdinand Wayne Lee

Address

Mercy Hospital

Date signed *10-21-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09624

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 31st St.**
(c) Hospital or institution: **U. S. Marine Hospital**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **10 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3308 W. Garrison Avenue**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME **ALBERT STANLEY BERRYMAN**

3 (b) If veteran, name war
World's War

3 (c) Social Security Account
No. **355-10-3287**

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Blida, Porta Berryman**
6 (c) If alive, give age **43** years

7. Birth date of deceased (mo., day, yr.) **3/16/98**

8. AGE: Years **45** Months **7** Days **12**
If less than one day
hr. min.

9. Birthplace **Baltimore, Md.**
(Town, county, and state)

10. Usual Occupation **Clerk - 10/1/43**

11. Industry or business **Bethlehem Fairfield**

FATHER 12. Name **Charles Berryman**

13. Birthplace **Reisterstown, Md.**

MOTHER 14. Maiden Name **Francianna Gardner**

15. Birthplace **Owings Mills, Md.**

16 (a) Informant **Records, U. S. Marine Hospital**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **11/1/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) **U. S. Marine Hospital** Balto. Nat'l. Cem.

Location **Balto. Md.**

18 (a) Funeral director **Wm. J. TICKNER & SONS**

(b) Address **Balto., Md.**

19 (a) (b)

30 1943

Huntington

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **October 28, 1943, at 9:45 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **October 18, 1943, to Oct. 28, 1943** and that I last saw him alive on **Oct. 28, 1943**

Immediate cause of death **Post operative shock; & cerebral edema**

Duration
1 day

Due to **Encephalopathy due to trauma (operative)**

1 day

Due to

Other Conditions **Menier's Syndrome**

Unk.

(Include pregnancy within 3 months of death)

Date of operation **10/27/43 - Craniotomy with section of the 8th cranial**

Major findings of operation: **nerve.**

As above

of autopsy: **None**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **NO**

(b) Date of occurrence at **M**

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify if public place)

(e) Means of injury

23. Signature

Address **Baltimore, Md.** Date signed **10/29/43**

Va-13858

09625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09625
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color/race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1943 to Oct. 29 1943 and that I last saw him alive on Oct. 27 1943.

Immediate cause of death

Cardio-vascular disease.

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09626
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

618 N. Bruce St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State

md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

618 N. Bruce St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles H. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

colored

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

Lydia Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1867

8. AGE:

Years

Months

Days

If less than one day

74

hr.

min.

9. Birthplace

Virginia

10. Usual Occupation

Janitor

11. Industry or business

FATHER

12. Name

Henry Robinson

13. Birthplace

Virginia

MOTHER

14. Maiden Name

Lillie Scott

15. Birthplace

Virginia

16 (a) Informant

George Robinson

(b) Address

418 N. Bruce St

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

10/28/43

(c) Cemetery or crematory

Mt. Calvary

Location

St. A. Co. Md.

18 (a) Funeral director

Chas. H. Alexander

(b) Address

927 N. Mount St

19 (a)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 28 1943, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to Oct 28 1943.

and that I last saw him alive on Oct 27 1943.

Immediate cause of death

Cardiac Failure

Due to

Valvular Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Douglas Sheppard, M.D.

23. Signature

Douglas Sheppard, M.D.

Address

1631 W. Franklin St

Date signed 10/29/43

Duration

1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

G 09627

PLACE OF DEATH

CITY OF BALTIMORE:

808-n. Gay

St. Ward)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city or town where death occurred

mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

Doris E. Adams

If U. S. Veteran specify WAR

(a) Residence: No.

808-n. Gay

St. 10-2

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. Color or Race 5. Single, Married, Widowed, or Divorced (write the word)

6a. If married, widowed, or divorced, HUSBAND of (or) WIFE of

7. DATE OF BIRTH (month, day, year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town, State or country)

13. NAME

14. BIRTHPLACE (city or town, State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town, State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Date

19. UNDERTAKER (Address)

20. FUNERAL

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year)

22. HEREBY CERTIFY That I attended deceased from 10/15-43 to 10/29-43

I last saw her alive on 10/29-43 Death is said to have occurred on the date stated above, at 5 A.M.

The principal cause of death and related causes of importance were as follows:

Pneumonia

sinusitis

Other contributing causes of importance

Symptomatic end. pharyngitis

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

(Signed) Jas. R. Blakey

(Address) 1327-n. Central

OCCUPATION is very important. See instructions on back of certificate.

VS 2

09628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09628

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 876 Washington Blvd.

(c) Hospital or institution:

DOCTORS HOSPITAL(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.(b) County Baltimore(c) City or town Pikesville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 7019 Alden Road

(If rural give location)

(e) If foreign born, how long in U. S. A. — years

3 (a) FULL NAME

(male baby)FEAR3 (b) If veteran, name war —3 (c) Social Security Account No. —

4. Sex

male

5. Color or race

white6 (a) Single, married, widowed, or divorced single6 (b) Name of husband or wife —6 (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) 10-27-438. AGE: Years — Months — Days 1 If less than one day — hr. — min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual Occupation —11. Industry or business —12. Name Albert Louis FEAR13. Birthplace Baltimore, Md.14. Maiden Name Juanita M. HAUPTON15. Birthplace Baltimore16 (a) Informant Juanita M. Fear(b) Address Pikesville17 (a) Buried (b) Date thereof 10/30/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory London Park
Location Baltimore18 (a) Funeral director William J. Brown(b) Address 1348 11th St19 (a) OCT 30 1943 (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28th 1943, at 7 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-1943 to 10-28-1943, and that I last saw him alive on 10-28-1943.

Immediate cause of death

atelectasisDue to —Due to —Other Conditions —

(Include pregnancy within 3 months of death)

Major findings: —Of operations —Of autopsy —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence —

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —

(Specify type of place)

(e) Means of injury —23. Signature Louis J. Glan

M. D.

Address 876 Washington Blvd Date signed 10-28-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09629

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09629
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Cabot & Sanatoga St.*
(c) Hospital or institution: *Mary Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *4 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balto.*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2911* *Prattman St.*
(If rural give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Cecilia Bettin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *W.* 6 (a) Single, married, widowed, or divorced *Married*

6 (b) Name of husband or wife *Joseph Bettin*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 10, 1881*

8. AGE: Years *62* Months *6* Days *4* hr. *19* min. *19*

9. Birthplace *Huntington, Md.*
(City, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *James Hughes*

13. Birthplace *Md.*

14. Maiden Name *Margaret Clark*

15. Birthplace *Md.*

16 (a) Informant *Record*

(b) Address *Mary Hospital*

17 (a) *Burial* (b) Date thereof *11/2/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Catholic Cem.*

Location

18 (a) Funeral director *Mary M. Miedel*

(b) Address *78 22nd St*

19 (a) *Oct 30 1943*

Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 29 1943* at *10¹⁵ AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 28 1943* to *Oct 29 1943*, and that I last saw him alive on *Oct 29 1943*.

Immediate cause of death

Cardiac Failure

Due to *Coronary - vascular*

Accident

Due to

Other Conditions *Diabetes*

(Include pregnancy within 3 months of death)

Date of operation *None*

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury *F. Payne Lee*

23. Signature *F. Payne Lee*

Address *Mary Hospital* Date signed *10/29/43*

DURATION

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9630

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

61

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1653 Clifton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(d) Street No.

(If outside city or town limits, write RURAL and give town)

1653 Clifton Ave

(e) Citizen of foreign country?

(If rural give location)

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Elizabeth Walters (ne Dietel)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Engineer L. Walters

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

June 29th 1879

8. AGE:

Years

Months

Days

If less than one day

64

3

29

hr.

min.

9. Birthplace

Balto., Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

George Dietel

13. Birthplace

Balto., Md.

14. Maiden Name

Elizabeth Schraden

15. Birthplace

Balto., Md.

16 (a) Informant

Miss Helena H. Walters

(b) Address

1653 Clifton Ave.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

11/1/1943

(c) Cemetery or crematory

London Park

Location

Balto., Md.

18 (a) Funeral director

Geo. Wilson & Son

(b) Address

2503 Edmondson Ave.

(c) Date read by registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 28th 1943. at 2:20 P.

21. I certify that death occurred on the date above stated; that I attended deceased from 1933 to Oct 28 1943.

and that I last saw him alive on Oct 26 1943.

Immediate cause of death

Diphtheria gangrene

Ischaemic

Due to

hypertension

Due to

coronary artery disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

W. H. Jones

Address 2818 N. Park

Date signed 10/29/43

09632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09632

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2309 W. Lammale St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2309 W. Lammale St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William E. (Zies) ZIES

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.MaleWhiteMarried

6 (b) Name of husband or wife

Elizabeth H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3/8/77

8. AGE:

Years

Months

Days

If less than one day

66821

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Mgr.

11. Industry or business

Chas. Zies & Sons

FATHER

12. Name

Charles Zies

13. Birthplace

Germany

MOTHER

14. Maiden Name

Elizabeth M. Schantz

15. Birthplace

Germany

16 (a) Informant

Mrs. Elizabeth H. Zies

(b) Address

2309 W. Lammale St.

17 (a) Burial

(b) Date thereof Nov. 1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Meadow Ridge

Location

Borsey, Md.

18 (a) Funeral director

Harry F. White

(b) Address

401 E. Lombard Ave.

OCT 30 1943

Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1943, at 10 AM

21. I certify that I took charge of the remains described above, held an

Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to this death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Arteriosclerosiscardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed October 29, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Dr. Berry
E. 65633
Registered No. 4813

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1630 E. Madison St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-5

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(d) Street No. 1630 E. Madison St
(If outside city or town limits, write RURAL and give town)
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Sadie Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1887

8. AGE: Years Months Days If less than one day

56

hr. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace VA

14. Maiden Name Unknown

15. Birthplace VA

16 (a) Informant Robert Belton Jr

(b) Address 1716 E. Madison St

17 (a) Burial (b) Date thereof 11-1-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. J. Co

18 (a) Funeral director Palmer Sanders

(b) Address 1412 E. Preston St

19 (a) OCT 30 1943

(b) Hunterton Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1943 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1942 to 10-28 1942, and that I last saw him alive on 10-28 1942.

Immediate cause of death

Acute myocarditis

Due to Cystitis

Carcinoma of uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. S. Berry

Address 1430 E. Chene Date signed 10-29-43

Duration

10

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Dr. Browne Sec E. Madison St.
09634
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1025 N. Central ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Central ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas B. Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

col

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

FEB 12/1884

8. AGE: Years Months Days

57 59

8

15

If less than one day

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Thomas Milburn

13. Birthplace

St. Marys County Md

MOTHER

14. Maiden Name

Martha Senwick

15. Birthplace

St. Marys Milburn

16 (a) Informant

Ida Jane Milburn

(b) Address

1025 N. Central ave

17 (a)

Burial

(b) Date thereof

OCT 31-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or place of interment

Arbutus Memorial

Location

Arbutus

18 (a) Funeral director

Rayner Sanders

(b) Address

1412 E. Preston St

19 (a)

OCT 30 1943

(b)

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

OCT 27 1943 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9:25 1943 to 10:27 1943 and that I last saw him alive on 10:27 1943.

Immediate cause of death

Carcinoma of liver.

Duration

1 1/2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Aug. 1942

Major findings of operations

Carcinoma.

of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Rayner Sanders

M. D.

Date signed 10-29

Rayner Browne

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09635

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks.

(e) Length of stay in Baltimore (yrs., mos., or days) 4 wks.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2514 E. Madison Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Baby Robert Lee Vogt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1943

8. AGE: Years Months Days If less than one day
1 33 3 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Joseph C. Vogt

13. Birthplace Baltimore, Md.

14. Maiden Name Emily Heyda

15. Birthplace Baltimore, Md.

16 (a) Informant Parents

(b) Address 2514 E. Madison Street

17 (a) Burial (b) Date thereof 10/30/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1943, 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1943 to Oct. 24 1943, and that I last saw him alive on Oct. 28 1943.

Immediate cause of death

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Christian F. Richter M.D.

Address St. Joseph's Hosp. Date signed 10/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 30 1943

09636

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09636
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caroline's Tavern St.*

(c) Hospital or institution:

St Joseph's Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10-16-43-10-28-43*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *529 N. Robinson St #5*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country.

3 (a) FULL NAME

August G. Matthews

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. *212-01-6854*4. Sex *Male*5. Color or race *White*

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

*Ida Matthews*6 (c) If alive, give age *53* years

7. Birth date of deceased (mo., day, yr.)

*Sept 24, 1890*8. AGE: Years *53* Months *1* Days *4*

If less than one day

hr.

min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation

Press Man

11. Industry or business

*News*12. Name *Conrad Matthews*13. Birthplace *Baltimore*14. Maiden Name *Christina Carter*15. Birthplace *Germany*16 (a) Informant *Mr Ida Matthews*(b) Address *529 N. Robinson St.*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Nov 1, 1943*

(month) (day) (year)

(c) Cemetery or crematory

Location *Eastern Ave*18 (a) Funeral director *S. Walter May*(b) Address *619 N. Pauldin St.*19 (a) *Thurston Williams, M.D.*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 28, 1943* at *10 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *10-16 1943* to *10-28 1943*, and that I last saw him alive on *10-28 1943*.Immediate cause of death *Coronary heart failure*Due to *Arteriosclerosis Cordis Vascular disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Thurston Williams*Address *St Joseph's Hospital* Date signed *10-28-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully submitted. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 30 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

89637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 09637

157E

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3017 Belair Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

10 days

2. USUAL RESIDENCE OF DECEASED:

(a) State

Ind

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3017 Belair Rd

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

William Lawrence Moon

MOON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 20 1943

8. AGE:

Years

Months

Days

If less than one day

10

hr.

min.

9. Birthplace

Baltimore Ind

(Town, county, and state)

10. Usual Occupation

Student

11. Industry or business

12. Name

James E Moon Jr

13. Birthplace

Little Rock Ark.

14. Maiden Name

Mary K Runyon

15. Birthplace

Phillipsburg Kan.

16 (a) Informant

James E Moon

(b) Address

3017 Belair Rd

17 (a)

Burial

(b) Date thereof

10/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore Cem.

Location

Baltimore, Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

001 30 1943

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30 1943 at 7:20 A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1943 to Oct 30 1943, and that I last saw him alive on Oct 30 1943.

Immediate cause of death

Myocardial Infarction

Due to

Due to

Other Conditions

His Carotid

Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. E. Moon

Address

2878 Ketter Rd

Date signed

10/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

509638

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

509638
46a
Registered No. 2-09638

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Calver & Saratoga Sts*
(c) Hospital or institution: *Mercy Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *156*
(e) Length of stay in Baltimore (yrs., mos., or days) *30 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*
(c) City or town *Baltimore* (If outside city or town limits, write RURAL and give town)
(d) Street No. *1522* *MS Kean* (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Benjamin Denaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Christina Denaro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 27 - 1903

8. AGE:

Years

Months

Days

If less than one day

40

04

2

hr.

45

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual Occupation

Milk man

11. Industry or business

Dairy

MOTHER FATHER

12. Name

Damiano Denaro

13. Birthplace

Italy

14. Maiden Name

Angela Randazzo

15. Birthplace

Italy

16 (a) Informant

Christina Denaro

(b) Address

1522 MS Kean Ave.

17 (a)

Burial

(b) Date thereof

Nov 2nd 49

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

400 2nd St 632

Funeral Director

Charles F. Towell

(b) Address

2427 Edmondson Ave

(Name filled by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 29 1942, 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 14 1942*, to *Oct 29 1942*, and that I last saw him alive on *Oct 29 1942*.

Immediate cause of death

acute

circulatory failure

Duration

8 hrs.

Due to

Peritonitis and

paralytic ileus

Due to

Post operative

condition

4 days

6 hrs.

Other Conditions

Carcinoma

of esophagus.

(Include pregnancy within 3 months of death)

Date of operation

Oct 19, 1942

Major findings of operation:

Carcinoma

of esophagus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert F. Berry

Address

Mercy Hospital

M.D.

Witnessed 10/29/42

(over)

G 09539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ky (b) County

(c) City or town Lowell

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Blenna Heaton

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Jack Heaton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1916

8. AGE:

Years

Months

Days

If less than one day

27

hr.

min.

9. Birthplace

Tennessee

(Town, county, and state)

10. Usual Occupation

Shipyard Worker

11. Industry or business

FATHER

12. Name

Sam Paul

13. Birthplace

Kentucky

14. Maiden Name

Mary Sheaton

15. Birthplace

Harlan, Kentucky

16 (a) Informant

Harbert Cowood

(b) Address

Harlan, Kentucky

17 (a)

(b) Date thereof

10/30/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Rest Haven

Location

Rest Haven, Kentucky

18 (a) Funeral director

Thompson

(b) Address

1217 1st Ave. N.E.

OCT 31 1943

(b) Hunterdon Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1943, at 10:05 PM

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Sub-dural - sub-arachnoid

Hemorrhage

Due to

Other Conditions Subdural 9 1/2 cm

vertebrae - Multiple fractures dorsum, lumbar, & sacrum

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-27- at 10:05 PM

(b) Where did injury occur? Play Hotel, Class. & Int. Royal

(c) Did injury occur at home, on farm, industrial place, in public

place? Public

While at work? Yes

(d) Means of injury Blunt force

23. Signature Hunterdon Williams

M.D.

Date signed 10-28-43

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09640		BALTIMORE CITY HEALTH DEPARTMENT		G 09640	
CERTIFICATE OF DEATH		186a		Registered No.	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:			
(a) Baltimore City, Maryland		(a) State <u>MD</u> (b) County <u>Balto</u>			
(b) Street address <u>Inland & Rayner St.</u>		(c) City or town <u>Balto</u> (If outside city or town limits, write RURAL and give town)			
(c) Hospital or institution <u>West Baltimore Hosp.</u>		(d) Street No. <u>4406 Springdale</u> (If rural give location)			
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>25d</u>		(e) Citizen of foreign country? (Yes or No)			
(e) Length of stay in Baltimore (yrs., mos., or days)		If yes, name country			
3 (a) FULL NAME <u>Sara Hopkins</u>		MEDICAL CERTIFICATION			
3 (b) If veteran, name war		20. DATE OF DEATH <u>Oct. 29</u> 19 <u>43</u> <u>4:20 P.M.</u>			
3 (c) Social Security Account No.		21. I certify that death occurred on the date above stated; that I attended deceased from <u>Oct 4</u> 19 <u>43</u> to <u>Oct 29</u> 19 <u>43</u> , and that I last saw her alive on <u>Oct 4</u> 19 <u>43</u> .			
4. Sex <u>F</u>	5. Color or race <u>W</u>	6 (a) Single, married, widowed, or divorced <u>W</u>			Immediate cause of death <u>Heart failure</u>
6 (b) Name of husband or wife <u>Jacob</u>		6 (c) If alive, give age years			Due to <u>myocardial disease</u>
7. Birth date of deceased (mo., day, yr.) <u>1860</u>					Due to <u>(arteriosclerotic)</u>
8. AGE: Years <u>83</u> Months Days If less than one day hr. min.					Other Conditions <u>Intertrochanteric fracture of femur</u> (Include pregnancy within 8 months of death)
9. Birthplace <u>Russia</u> (Town, county, and state)					Date of operation
10. Usual Occupation <u>None</u>					Major findings of operations
11. Industry or business					of autopsy
12. Name <u>Loz</u>					22. If death was due to external causes, fill in the following:
13. Birthplace <u>Russia</u>					(a) Accident, suicide, or homicide <u>Accident</u>
14. Maiden Name <u>Hannah</u>					(b) Date of occurrence <u>Oct 28 1943 4 P.M.</u>
15. Birthplace <u>Russia</u>					(c) Where did injury occur? <u>Home - 4406 Springdale</u> (City or town) (County) (State)
16 (a) Informant <u>Hosp. Records</u>					(d) Did injury occur about home, on farm, industrial place, in public place? <u>Home</u> While at work? <u>No</u> (Specify type of place)
(b) Address					(e) Means of injury <u>Fall from chair in her home</u>
17 (a) <u>Burial</u> (b) Date thereof <u>10-31-43</u> (Burial, cremation, or removal) (month) (day) (year)					23. Signature <u>Harvey S. Shubert</u> M.D.
(c) Cemetery or crematory <u>Windsor Hill Rd.</u>					Address <u>2703 Chumley</u> Date signed <u>10-29-43</u>
Location <u>Windsor Hill Rd.</u>					
18 (a) Funeral director <u>Jack Lewis</u>					
(b) Address <u>1439 E. Balto St.</u>					
19. Date rec'd by registrar <u>Oct 31 1943</u>					
20. For <u>Dr. L. Williams</u> By <u>Harvey S. Shubert, M.D.</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09641

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 30 1943 at 10 P. M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 2-15 1942 to 10-30 1943,

and that I last saw him alive on 10-30 1943.

Immediate cause of death Cerebral Hemiplegia

Atherosclerosis

Hypertension

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

in Zierler 2318 E. 1st St. Baltimore
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Information

(b) Address

17 (a) Removal

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Address

(d) Address

(e) Address

(f) Address

(g) Address

(h) Address

(i) Address

(j) Address

(k) Address

(l) Address

(m) Address

(n) Address

(o) Address

(p) Address

(q) Address

(r) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1943, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943 to Oct 29 1943.

and that I last saw her alive on Oct 29 1943.

Immediate cause of death

acute congestive heart failure

Due to chronic myocarditis

as extensive sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 31 1943

G 09643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09643

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4613 Park Heights Ave

(c) Hospital or institution:

Mt. Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

ESTHER LESSER (NEE GOLDMAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Hyman Lesser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1871

8. AGE:

Years

Months

Days

If less than one day

72

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Julius Goldman

13. Birthplace

Russia

14. Maiden Name

Martha

15. Birthplace

Russia

16 (a) Informant

Morris Goldmann

(b) Address

1434 Ormand Ave Camden

17 (a)

Burial

(b) Date thereof

10-31-43

(Burial, cremation, or removal)

(c) Cemetery or crematory

Nichols Lodge Cong

Location

High St. B'way

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E. Baltimore St

(c) Date

10-31-43

(Date rec'd by registrar)

Winnington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

4227 Pimlico Rd.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1943 at 3:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEP 27 1943 to OCT 30 1943 and that I last saw her alive on OCT 30 1943

Immediate cause of death

Cerebral Hemorrhage

Due to

Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

M. D. Robert

4613 Park Heights Ave

Date signed

M. D.

10/31/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09644

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3901 Keswick Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---

(e) Length of stay in Baltimore (yrs., mos., or days) About 86 yrs.

3 (a) FULL NAME

William V. Heaphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Virginia Kershner

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) --- 57

8. AGE: Years Months Days If less than one day
About 86 --- -- -- hr. --- min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Richard Heaphy

13. Birthplace Ireland

14. Maiden Name Bridget Harrigan

15. Birthplace Ireland

16 (a) Informant Miss Margaret Heaphy

(b) Address 3901 Keswick Road

17 (a) Burial (b) Date thereof 11/1/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meers and Son

(b) Address 805 N. Calvert Street

OCT 30 1943 (b) Huntington Williams, M.D. Address 2504 St. Paul St.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County ---

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3901 Keswick Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1943, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1942, to Oct. 28 1943, and that I last saw him alive on Oct. 27 1943.

Immediate cause of death

Coronary occlusion

Due to Chronic Myocarditis

Due to General ataxia

Other Conditions Arteriosclerosis & General Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. W. Meers and Son Date signed 10/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09645

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1301 Nerkiner St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1301 Nerkiner St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

MOTIEJUS KASINSKAS

3 (b) If veteran, name war

(c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 - 1887

8. AGE: Years 56 Months 5 Days 14 hr. min.

9. Birthplace

Lithuania

(Town, county, and state)

10. Usual Occupation

Tailor

11. Industry or business

12. Name

Joseph Kasinskas

13. Birthplace

Lithuania

14. Maiden Name

?

15. Birthplace

Lithuania

16 (a) Informant Margaret Kasinskas

(b) Address 1301 Nerkiner St

17 (a) Burial (b) Date thereof 11 - 3 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Plain Rd.

18 (a) Funeral director Joseph Kasinskas Inc

(b) Address 602 Washington Rd

19 (a) (b) Huntington Williams, M.D.

OCT 30 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1943 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 24 1943 to Oct 29 1943 and that I last saw him alive on Oct 24 1943.

Immediate cause of death

Bronchopneumonia

Due to

Bronchopneumonia

Due to

Hypertension

Other Conditions

Ac. Arteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. S. MARR

M. D.

Address 216 Cathedral St. Date signed Oct 29 1943

Ernest S. MARR

Duration

acute

6 Months

acute

3 Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09646

Registered No.

- 82330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Frank Kahler

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
M5. Color or race
W6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of husband or wife

Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

MAR. 5, 1903

8. AGE: Years Months Days If less than one day
40 7 24 23 hr min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name

Jacob

13. Birthplace

Md.

14. Maiden Name

Emma Gabel

15. Birthplace

Md.

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal)

Burial

(b) Date thereof (month) (day) (year)
Nov 1-1943

(c) Cemetery or crematory

Mount Carmel

Location

Odonnell St

18 (a) Funeral director

Lilly & Zeller INC

(b) Address

403 S. Wolfe St.

19 (a) Registrar

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1943, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1943 to 10-28 1943, and that I last saw him alive on 10-28 1943.

Immediate cause of death

Pulmonary tuberculosis

Duration

?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Paul Mattman

Address

B. C. H.

Date signed 10/29/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 31 1943

VS 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09647

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

St. Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 2 d.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Balto.

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1213 Light

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

BABY BOY WOLVERTON.

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29-1943

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Balto., Maryland.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

None

FATHER
MOTHER

12. Name

Charles Wolverton (Father)

13. Birthplace

Baltimore Md

14. Maiden Name

Theresa Hohenstein

15. Birthplace

Baltimore Md

16 (a) Informant

Charles Wolverton

(b) Address

3710 Hudson St.

17 (a)

Burial

(b) Date thereof

Nov. 1-1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Sacred Heart

Location

German Hill Road

18 (a) Funeral director

Lilly and Geiler INC.

(b) Address

403 S. Wolfe St.

19 (a)

by registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/30

1943 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10/29 1943 to 10/30 1943.

and that I last saw him live on 10/30/43

Immediate cause of death

PREMATURITY

Due to

(4 1/4" of)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles R. McDonald

M. D.

Address 1213 Light St.

Date signed 10-30-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09648
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)(d) Street No. 543 S. Paca St.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1942

8. AGE: Years Months Days If less than one day
1 23 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Child

12. Name Willie J Randolph

13. Birthplace Va

14. Maiden Name Ethel Beasley

15. Birthplace Va

16 (a) Informant Willie J Randolph

(b) Address 543 S. Paca St

17 (a) Removal (b) Date thereof 10-31-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Prospect
Location Va

18 (a) Funeral director Isiah L. Brown & Co

(b) Address 108 W. Montgomery St

3 1943 (b) Death by registrar Huntington Williams

VB 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1943 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1943 to Oct. 29 1943, and that I last saw him alive on Oct. 29 1943.

Immediate cause of death

Non-specific Diarrhea

Due to

Due to Acute Gastric Enteritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. H. Kimfield

Address Provident Hospital

Date signed 10/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09649
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 29 1943, at 8:44 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1943, to Oct 29 1943.

and that I last saw him alive on Oct 28 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Joseph Pokorny

2200 E Madison

M. D.

Date signed 10/29/43

Duration

2 mos

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09650

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09650

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

Franklin Square

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Balto.

(c) City or town Rustertown

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Charles R. Carney

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1868

8. AGE:

Years

Months

Days

If less than one day

75

1

29

hr.

min.

9. Birthplace

Balto. Co

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

FATHER

12. Name

George Carney

13. Birthplace

Md.

MOTHER

14. Maiden Name

Elyzabeth Justice

15. Birthplace

Md.

16 (a) Informant

Kate Carney

(b) Address

Rustertown

17 (a)

Burial

(b) Date thereof

Nov 3 43

(month) (day) (year)

(c) Cemetery or crematory

Canvells Chapel

Location

Balto. Co

18 (a) Funeral director

J. F. Elmer, Sons

(b) Address

Rustertown Md.

19 (a)

1943

(b)

Huntington William, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-31

1943

at 10 A M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10-18 1943 to 10-31 1943.

and that I last saw him alive on 10-31 1943.

Immediate cause of death

Cerebral hemorrhage of head

of pancreas; infarction of liver

& bile ducts.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

10-24-43

Major findings of operations as above

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. P. T. Thomas

Address

1312 Lyster St

M. D.

Date signed

G 09651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09651

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Emma Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

7

W.

Married

6 (b) Name of husband or wife

Edward Becker

6 (c) If alive, give age

34 years

7. Birth date of deceased (mo., day, yr.)

7/24/14

8. AGE:

Years

Months

Days

If less than one day

29

3

5

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Samuel Barthuse

13. Birthplace

Md.

14. Maiden Name

Amelia Riffner

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Nov. 2 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Matthews Cem.

Location

O. Donnell Pl.

18 (a) Funeral director

J. P. Moran

(b) Address

300 E. Pratt St.

19 (a)

Date

10/29/43

Signature

H. W. Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/29/43

19

at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1943 to Oct 29 1943 and that I last saw him alive on Oct 29 1943.

Immediate cause of death

Lobar Pneumonia type III pneumonia

occurring (at)

Due to following operation for drainage of empyema (lt.)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-1-43 / 10-28-43

Major findings of operation: Empyema

Causes

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles Stinson Welch,

M. D.

Address J.H.A. - Baltimore Md. Date signed 10-27-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

OCT 31 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Balt. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Windsor
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gus C. FRANZ

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/1876
8. AGE: Years 68 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business Drug

FATHER
12. Name Conrad Franz
13. Birthplace Germany
MOTHER
14. Maiden Name Theresia Amberg
15. Birthplace Germany

16 (a) Informant Eleanor Franz
(b) Address 3038 Windsor Ave

17 (a) Burial (b) Date thereof 11-3-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Loring Biers
(b) Address 5005 Park Heights Ave

19 (a) Date of death Nov 1 1943 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1943 at 4:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1943 to 10/30 1943, and that I last saw him on 10/30 1943.

Immediate cause of death arterio-sclerotic heart disease.

Due to
Due to

Other Conditions
(Include pregnancy within 2 months of death)
Date of operation
Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. McDonald M.D.
Address 1413 Light St Date signed 10-30-43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

NOV 1 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 09653

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 5222 Florence Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5222 Florence Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Eugene Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Clara Brasley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6/20/1867

8. AGE:

Years

Months

Days

If less than one day

76

3

29

hr.

min.

9. Birthplace

Waterford N. J.
(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Eng. (Fog Boat) Standard Oil

FATHER

12. Name

Wm. F. Perkins

13. Birthplace

Unknown

MOTHER

14. Maiden Name

Mary Hardester

15. Birthplace

Unknown

16 (a) Informant

E. Leonard Perkins

(b) Address

5222 Florence Ave.

17 (a)

Burial

(b) Date thereof

11-1-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

Baltimore Md.

18 (a) Funeral director

Loring Byers

(b) Address

5005 Park Heights

19 (a)

(Date recorded)

11-1-43

NOV 1 1943

VI 114

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 29 1943 at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1943 to 10/29 1943, and that I last saw him alive on 10/25 1943.

Immediate cause of death

Paralysis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

10/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09654

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2325 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME

Cora L. Caves

3 (b) If veteran, name war

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Newton B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 16, 1888

8. AGE: Years Months Days

55

6

14

If less than one day

hr.

min.

9. Birthplace

Staunton, Va.

10. Usual Occupation

Housewife

11. Industry or business

12. Name

Jamie Blair

13. Birthplace

Virginia

14. Maiden Name

Annella ? ?

15. Birthplace

Virginia

16 (a) Informant

Harold Barty

(b) Address

2325 Druid Hill Ave.

17 (a) Burial

(b) Date thereof Nov. 2, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Staunton, Va.

18 (a) Funeral director

Mrs. L. A. Hollander

(b) Address

1631 Druid Hill Ave.

19 (a) NOV 1 1943

(b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1943, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 29 1943, to October 29 1943, and that I last saw him alive on October 29 1943

Immediate cause of death

Cerebral Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Charles J. Ward

Address

861 Avenue A

Date signed

10/31/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09655
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Saratoga St*

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *38 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *38 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md.*

(b) County *Baltimore*

(c) City or town

Monkton md.
(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country

3 (a) FULL NAME

William Wathin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

so

6 (a) Single, married, widowed, or divorced.

M

6 (b) Name of husband or wife *Jessie Wathin*

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) *July 4, 1871*

8. AGE: Years Months Days *72 3 27* hr. min.

9. Birthplace *Balt. County Md.*
(Town, county, and state)

10. Usual Occupation *unemployed*

11. Industry or business

12. Name *John Wathin*

13. Birthplace ?

14. Maiden Name *Jessie Burris*

15. Birthplace ?

16 (a) Informant *Jessie Wathin*

(b) Address *Monkton Md.*

17 (a) *Burial* (b) Date thereof *Nov. 3, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *St. Luke's*

Location *Monkton, Md.*

18 (a) Funeral director *London M. Wright*

(b) Address *Sparks, Md.*

19 (a) *NOV 1 1943* (b) *Huntington Williams*

20. DATE OF DEATH *Oct 31* 19*43*, at *1:10 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/23* 19*43* to *10/31* 19*43* and that I last saw him alive on *10/21* 19*43*

Immediate cause of death *Resp. Failure*

Due to *Pneumonia*

Due to *Post-oper. Prostatectomy*

Other Conditions *Dehydrated*

Hypertension
(Include pregnancy within 3 months of death)

Date of operation *10/2/43*

Major findings of operation.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Marcus L. Adenboldt Jr.*

Address *Mary Hosp.* Date signed *11/1/43*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 31* 19*43*, at *1:10 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *9/23* 19*43* to *10/31* 19*43* and that I last saw him alive on *10/21* 19*43*

Immediate cause of death

Resp. Failure

Due to *Pneumonia*

Due to *Post-oper. Prostatectomy*

Other Conditions *Dehydrated*

Hypertension
(Include pregnancy within 3 months of death)

Date of operation *10/2/43*

Major findings of operation.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Marcus L. Adenboldt Jr.*

Address *Mary Hosp.* Date signed *11/1/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09656

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 09656
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *Cabot & Saratoga Sts.*
(c) Hospital or institution: *Mercy Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *60 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *49 yrs.*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *Baltimore*
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *2205 Ritten St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Palmer B. Hasson

3 (b) Veteran, name was

World War

3 (c) Social Security Account

No. *705-09-1603*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Mari Hasson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 23, 1942

8. AGE: Years

49

Months

3

Days

6

If less than one day

hr. 50 min.

9. Birthplace

Baltimore, Md.

10. Usual Occupation

Clerk B & O Ry.

11. Industry or business

Rail road

12. Name

Samuel Hasson

13. Birthplace

Maryland

14. Maiden Name

Virginia W. Ship.

15. Birthplace

Virginia

16 (a) Informant

Mrs. Mari Hasson

(b) Address

2205 Ritten St.

17 (a) *Burial* (b) Date thereof *Nov 1, 1943*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Green Valley

Location

Easton Ave

18 (a) Funeral director

Bellevue City

(b) Address

Bellevue City

Nov 1 - 1943 (b) *Funerary Association, Md.*

Date rec'd by Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 28, 1943, at 6:50 A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 23, 1943, to Oct. 28, 1943,* and that I last saw him alive on *Oct. 25, 1943.*

Immediate cause of death *Circulatory*

failure

Due to *Generalized*

Pericarditis

Due to *Pericardial*

infection & thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *Oct 23, 1943*

Major findings of operation: *Pericardial*

infection & thrombosis

of autopsy: *Pericarditis*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: *Robert F. Berry*

Address: *Mercy Hospital*

Date signed: *11/2/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09657

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

3 (a) FULL NAME

Halter Taft

3 (b) If veteran, name war

W

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Mrs Helen Taft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1906

8. AGE: Years Months Days If less than one day

37

9

28

hr.

min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Cleric

11. Industry or business

12. Name Samuel Taft

13. Birthplace Prince George Co. Md

14. Maiden Name Lenora Campan

15. Birthplace Baltimore Md

16 (a) Informant Mrs Helen Taft

(b) Address 1417 Homestead St. Baltimore

17 (a) Cremation (b) Date thereof 11/2/43

(month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 NOV 1 - 1943 Huntington Williams M.D.

(Date rec'd by)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1417 Homestead St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1943 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943, to Oct 31 1943, and that I last saw him alive on Oct 31 1943.

Immediate cause of death

Brain tumor - right frontal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 26

Major findings of operations:

Brain tumor - right frontal

of autopsy Brain tumor, right frontal

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Isabella Harrison

Address Church Home & Hospital Date signed 10/31/43

Duration

6 weeks

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09658

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09658

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09659

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JOHN AIKIN

3 (b) If veteran, name was

NO

3 (c) Social Security Account

No. NONE

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Annie Aiken

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

April 22nd 1868

8. AGE:

Years

Months

Days

If less than one day

75

6

8

hr.

min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

(Unknown)

Aiken

13. Birthplace

Canada

14. Maiden Name

"

15. Birthplace

"

16 (a) Informant

Anna Lila Schmelz

(b) Address

1440 Fillmore St.

17 (a)

Burial

(b) Date thereof

11/2/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Balto

Location

Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1440

Fillmore St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30 1943 at 5:25 PM

21. I certify that I took charge of the remains described above, held an

autopsy, inspection or inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of skull and
hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

10-30-43 at 3 a. 9/5 M.

(b) Where did injury occur?

254 St. Paul St

(c) Did injury occur at home, on farm, industrial place, in public

place?

Public

While at work?

(d) Means of injury

pedestrian struck by auto

23. Signature

H. L. Williams, M.D.

M.D.

Date signed 10-30-43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 1 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 03660

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 03660

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 22 S. Athol Ave.

(c) Hospital or institution:

General German Aged Peoples Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 22 S. Athol Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henry Bokhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Margaret Pausch Bokhardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1867.

8. AGE: Years 76 Months Days 15 If less than one day hr. min.

9. Birthplace N.Y.

(Town, county, and state)

10. Usual Occupation Retired Piano Polisher

11. Industry or business

12. Name Henry Bokhardt

13. Birthplace Germany

14. Maiden Name Marie Scheat

15. Birthplace Germany

16 (a) Informant Mr. J. George Walz,

(b) Address 22 S. Athol Ave.

17 (a) Burial (b) Date thereof Nov. 2/43.

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral Home Harry J. Pustke

(b) Address 4101 Edmondson Ave.

19 (a)

(Date and by registrar)

NOV 1 - 1943

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Oct. 30/43. 19 at 7/20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28/43. to Oct. 30/43. and that I last saw him alive on Oct. 29/43.

Immediate cause of death

Cerebral Hemorrhage.

Duration

2 days

Due to

Due to

Other Conditions

Mitral Regurgitation.

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address

Henry J. Pustke
933 Thumm Dr. Baltimore, Md.
10/30/43

Unknown.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 09661

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W 40th ST

(c) Hospital or institution:

The Home for the Aged

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

3 (a) FULL NAME

Mr. Frank T. Whitney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Alexandra Whitney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1926

8. AGE: Years 87 Months 8 Days 12 hr. min.

9. Birthplace Wrockton, Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Geo. Redington Whitney

13. Birthplace Duxbury, Mass

14. Maiden Name Pauline Hillard

15. Birthplace Provincetown, Mass

16 (a) Informant M. L. Bawdon

(b) Address 700 W. 40th ST

17 (a) Burial, cremation, or removal (b) Date thereof Nov 1, 1943

(c) Cemetery or crematory Green Mount

Location East Mt

18 (a) Funeral director Henry W. Jenkins

(b) Address 11 E. Chase St

19 (a) 1-1943 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No 700 W 40th ST

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1943 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12, 1943, to Oct. 30, 1943, and that I last saw him alive on Oct. 30, 1943.

Immediate cause of death Bronchial Pneumonia

Due to

Due to

Other Conditions Hypertension, Cardiac Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas Connors M.D.

Address 11 E. Chase St

Date signed 10/30/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09662
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or ossuatory

Location

18 (a) Funeral director

(b) Address

NOV 1 - 1943

VS 100

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

Street No.

(e) Citizen of foreign country

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Oct 30 1943. and that I last saw him alive on Oct 30 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

23. Signature

Address

Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 09663

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Union Memorial Hosp*
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) *50 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *# 7 Hittings Ave*
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Grace Howard M. Gilpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

F *W* *married*
6 (b) Name of husband or wife *Arthington Gilpin*
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 20 1885
8. AGE: Years Months Days If less than one day
58 4 10 hr min.

9. Birthplace

Liberon New Jersey
(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

12. Name

Wm Howard Munnikhuysen

13. Birthplace

Belair Md

14. Maiden Name

Bessie Pancroast

15. Birthplace

Phila Pa

16 (a) Informant

Husband

16 (b) Address

7 Hittings Ave

17 (a) *Burial* (b) Date thereof *Nov 2 43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Green Mount
Location *Baltimore Md*

18 (a) Funeral director

Henry H. Jenkins 1500 E
(b) Address *McCulloch & Orchard St*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/30/43* 19 *at 11 P.M.*

21. I certify that death occurred on the date above stated that I attended deceased from *July* 19*41* to *10/30* 19*43* and that I last saw him alive on *10/28/43*

Immediate cause of death *Coronary Thrombosis*

Due to *arteriosclerosis*

Due to *myocarditis*

Due to *hypertension*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *H. H. Hardy*

Address *1408 Park Ave* Date signed *10/31/43*

Duration *30 min*

Hardy

Hardy

Hardy

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 1 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address 22 S. Athol Ave.
 (c) Hospital or institution: Ben L. Herman Aged Home.
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md (b) County
 (c) City or town Baltimore
 (d) Street No. 22 S. Athol Ave.
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME Mary E. Bowers
 3 (b) If veteran, name was
 3 (c) Social Security Account No.

4. Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced widowed
 6 (b) Name of husband or wife late George W.
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1872
 8. AGE: Years 71 Months 6 Days 6 If less than one day hr. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual Occupation
 11. Industry or business

12. Name Moses K. Fleming
 13. Birthplace Pyra.
 14. Maiden Name Mary E. Kimmel
 15. Birthplace Germany

16 (a) Informant Mr. W. H. W. (b) Address 22 S. Athol Ave.
 17 (a) Burial (b) Date thereof 11-1-43
 (c) Cemetery or crematory Mt. Olivet
 Location Exquisite Maryland

18 (a) Funeral director Harry A. W. (b) Address 4101 E. Baltimore Ave.
 19 (a) (Date rec'd by registrar) Registrar

20. DATE OF DEATH Oct 29 1943 at 2:40 P.M.
 21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10/43 to Oct. 29/43, and that I last saw her alive on Oct. 28/43.
 Immediate cause of death: Broncho-Pneumonia.
 Due to
 Due to
 Other Conditions Chronic Cardiac Hypertrophy.
 Date of operation
 Major findings of operations
 of autopsy:
 22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (e) Means of injury
 23. Signature Henry Reed Quinn M. D.
 Address 933 Haverhill Dr. Baltimore, Md.

Duration 5 days
 Unknown
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

VS 1 NOV 1 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09665
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1015 Shields St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female Colored

5 Color or race

6 (a) Single, married, widowed, divorced

6 (b) Name of husband or wife Joshua Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

41 4 2 11

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, limit to RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

20. DATE OF DEATH

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 1 - 1943

G 09666

BALTIMORE CITY HEALTH DEPARTMENT

G 09666

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1406 Donald Hill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edith A. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Milton A. Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1891

8. AGE: Years Months Days If less than one day

51 11 3 hr. min.

9. Birthplace Baltimore City Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name James Meyers

13. Birthplace Baltimore City Md.

14. Maiden Name Martha

15. Birthplace Baltimore City Md.

16 (a) Informant Milton A. Cook

(b) Address 1406 Donald Hill Ave

17 (a) Burial (b) Date thereof 11-1-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Park

Location Balt. Co. Md.

18 (a) Funeral director James A. Hendry

(b) 528 W. Biddle St.

19 (a) 1-1943

(Date rec'd by registrar) Huntington Williams, Jr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1406 Donald Hill Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 29 1943 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1943 to Oct 28 1943

and that I last saw her alive on Oct 28 1943

Immediate cause of death: Cardiac Ischemia Renal disease

Due to

Due to

Other Conditions: Premia + Hypertension

(Including pregnancy within 3 months of death)

Date of operation: none

Major findings of operations: L

of autopsy: L

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury S.B. Hughes

23. Signature

Address 1406 Donald Hill Ave

Date signed 11-3-43

Duration

?

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09667
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: 1101 Balt. Ave. N. Hops
(c) Hospital or institution: Rayner & Dubland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

LILLIAN SANDS

3 (b) If veteran, name war

✓

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11th 1864

8. AGE: Years Months Days If less than one day
79 8 20 hr. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

James W. Sands

12. Name

13. Birthplace

Charlotte D. Wilgore

14. Maiden Name

James W. Sands

15. Birthplace

Charlotte D. Wilgore

16 (a) Informant

Mr. Jennetta Patterson

16 (b) Address

2523 Edmondson Ave

17 (a) Burial

(Burial, cremation, or removal)

17 (b) Date thereof

11/2/43
(month) (day) (year)

17 (c) Cemetery or crematory

London Park
Location: Balt., Md.

18 (a) Funeral director

Mr. Weber & Son

18 (b) Address

2503 Edmondson Ave

18 (c) Date of funeral

NOV 1 - 1943

Funeral Home: Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/43 10²⁵ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20/43 to 10/31/43 and that I last saw him alive on 10/31/43

Immediate cause of death

Respiratory failure

Due to Cerebral Hemorrhage

Due to Hypertensive and Atherosclerotic Cerebral Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: George Shorofsky MD

Address: 1101 Balt. Ave. N. Hops

Witnessed 10/31/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09668
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 4 wks.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2402 Reschert Ave.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Leo Albert Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1943

8. AGE: Years Months Days If less than one day

29

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Louis A. Austin

13. Birthplace

Rhode Island

14. Maiden Name

Jean Blake

15. Birthplace

Baltimore, Md.

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Month, day, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Hospital authorities permission to
disposal of the body.

18 (a) Funeral director

(b) Address

Huntington Williams, Jr., M.D.

NOV 1 - 1943

(Date rec'd by registrar)

(b) Huntington Williams, Jr., M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1943. at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1943 to Oct. 9 1943, and that I last saw him alive on Oct. 9 1943.

Immediate cause of death Cardiac - respiratory failure

Duration

5 days

Due to

Bronchopneumonia

Due to

Other Conditions Paralytic ileus, congenital heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Bronchopneumonia; par. ileus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George W. Huntington, Jr.

Address 332 E. University Pkwy. Date signed 10/9/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09669

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 504 E 39th St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 374 E. 39th St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Becker

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28-1860

8. AGE: Years Months Days If less than one day

83

1

1

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

12. Name

Unknown

13. Birthplace

German

14. Maiden Name

Unknown

15. Birthplace

German

16 (a) Informant Mrs Marie M. Cylburg

(b) Address 504 E. 39th St

17 (a) Burial (b) Date thereof 11-1-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western

Location

18 (a) Funeral director

Leonard Ruff

(b) Address

5305 Highland Rd

19 (a) (b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10, 1943 to Oct 29 1943, and that I last saw him alive on Oct 29 1943.

Immediate cause of death

Pneumonia

Duration

1 week

Due to

Due to

Other Conditions Carcinoma of
Urinary Bladder
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

B. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Anthony J Thomas

Address 4600 York Rd

Date signed 11/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 125

NOV 1 - 1943

Baltimore, Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09670
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address: Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): 12 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Baltimore
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3124 Lawnview Ave
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME

Louise Brohmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife: Mr. Brohmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1871 Nov. 1st

8. AGE: Years Months Days If less than one day
71 yr 11 29 hr. min.

9. Birthplace: Germany
(City, county, and state)

10. Usual Occupation: mother (housewife)

11. Industry or business: Housewife

12. Name: Kupisch

13. Birthplace: Germany

14. Maiden Name: Louise Gursik

15. Birthplace: Germany

16 (a) Informant: Mr. Carl Brohmeyer (son)

(b) Address: 2132 Clifton Ave

17 (a) Burial (b) Date thereof: Nov. 3 1943
(month) (day) (year)

(c) Cemetery or crematory: Parkwood

Location: Baltimore, Md.

18 (a) Funeral director: Cassin Funeral Home

(b) Address: 7401 Belair Road

19 (a) Date of death: Nov. 1 1943

(b) Signature: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-30-43 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-43 to 10-30-43 and that I last saw her alive on 10-30-43

Immediate cause of death: Coronary occlusion

Due to: Anterior & lateral wall of left ventricle infarction

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury:

23. Signature: Raymond S. Rangle

M. D.

Address: Date signed:

RAYMOND RANGLE

09671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09671

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1002 Leadenhall St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *23*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Balti*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1002 Leadenhall St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Agnes Johnson Francis

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

*Married*6 (b) Name of husband or wife *Levy Francis*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 28-17*

8. AGE: Years Months Days If less than one day

*20**4**1*

hr.

min.

9. Birthplace *Baltimore Md*

(Town, county, and state)

10. Usual Occupation *Homemaker*

11. Industry or business

12. Name *Henry Johnson*13. Birthplace *N.C.*14. Maiden Name *Emma Saunders*15. Birthplace *Md*16 (a) Informant *Carrie Johnson*(b) Address *1002 Leadenhall St*17 (a) *Burial* (b) Date thereof *1/2/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Mt Calvary*Location *Q & Co. Md*18 (a) Funeral director *Isaiah L. Brown*(b) Address *108 W. Montgomery St*(c) *Huntington Williams, M.D.*23. Signature *David Francis*Address *122 W Lee*Date signed *11/1/43*

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/29/43* at *9 A* M21. I certify that death occurred on the date above stated that I attended deceased from *Sept 18 1943* to *Oct 29 1943* and that I last saw him alive on *Oct 28 1943*Immediate cause of death *acute**Pulmonary**Tuberculosis*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *David Francis*Address *122 W Lee*Date signed *11/1/43*

Duration

3 mos

09672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09672
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address: *Calvert and Saratoga Sts*
 (c) Hospital or institution: *Mary Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *3.5 yrs*

2. USUAL RESIDENCE OF DECEASED:
 (a) State: *MD* (b) County: *Balt*
 (c) City or town: *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *423 Rock Blum Rd*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country: *-*

3 (a) FULL NAME *John Francis Sharpe*
 3 (b) If veteran, name war: *-* 3 (c) Social Security Account No. *-*

4. Sex: *M* 5. Color or race: *W* 6 (a) Single, married, widowed, or divorced: *W*

6 (b) Name of husband or wife: *-* 6 (c) If alive, give age: *-* years

7. Birth date of deceased (mo., day, yr.) *May 18, 1879*
 8. AGE: Years *64* Months *5* Days *11* If less than one day: *-* hr. *-* min.

9. Birthplace: *Lanark, Penn*
 (Town, county, and state)

10. Usual Occupation: *Engineer*

11. Industry or business: *-*

FATHER 12. Name: *Hugh Sharpe*

13. Birthplace: *Lanark, Penn.*

MOTHER 14. Maiden Name: *Margaret B. McEwen*

15. Birthplace: *Hanilton, Penn.*

16 (a) Informant: *Reid*

(b) Address: *Mary Hospital*

17 (a) *Swirl* (b) Date thereof: *11-2-43*
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: *Catholic*

Location: *St. John's*

18 (a) Funeral director: *Emery & Son*

(b) Address: *Sutton & Fay*

NOV 1 1943 (b) *Huntington, N.Y.* Registrar

VB 160

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 29 1943* at *1:57 PM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 27 1943* to *Oct 29 1943*, and that I last saw him alive on *Oct 29 1943*.

Immediate cause of death: *Respiratory Failure*

Due to: *Cardiac Decompensation*

Due to: *Arteriosclerotic Heart Disease*

Other Conditions: *Hepatic degeneration*

(Include pregnancy within 3 months of death)

Date of operation: *None*

Major findings of operation: *-*

of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: *-* at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury: *-*

23. Signature: *Frederick Payne*

Address: *Mary Hosp* Date signed: *10/29/43*

Duration: *Heart Disease of 3 years duration*

PHYSICIAN
 Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157d

G 09673
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1830 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

John R Price Jr
3 (b) If veteran, name was
3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1925

8. AGE: Years 19 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Balto Md
(City, county, and state)

10. Usual Occupation
11. Industry or business

12. Name John F Price

13. Birthplace Maryland

14. Maiden Name Charles Ludwig

15. Birthplace Maryland

16 (a) Informant John F Price

(b) Address 1830 W Fairmount Ave

17 (a) Funeral (b) Date thereof 11-1-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Huntington

Location Balto Md

18 (a) Funeral director James A. Taylor

(b) Address Tulston & Jay-st

NOV 1 - 1943 (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1943 at 10:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1943 to 10/28 1943, and that I last saw him alive on 10/28 1943.

Immediate cause of death, Pneumonia, Bronchial

Due to Rheumatic Pan Carditis.

Due to Microcephalus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Namuel C. Bogorad, M.D.

Address 1905 W. Baltimore Date signed 11/1/43

Duration 4 days

Heart.

Brain.

PHYSICIAN

Underline the cause to which death should be charged statistically.

BOGORAD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09674

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *2819 N. Lafayette Ave*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *Life*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Date rec'd by registrar

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1943 to Oct 29 1943, and that I last saw him alive on Oct 28 1943.

Immediate cause of death *Cerebral embolism - Hemiplegia*

Due to *Chronic Endo + myocardial disease. Generalized arteriosclerosis.*
Due to *sclerosis.*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

NOV 1 1943

VB 150

G 09675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09675

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

700 W. 40th St

(c) Hospital or institution:

Nurse for L. ensable

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

700 W. 40th St.

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

3 (a) FULL NAME

Lisette Hennighausen

(Lisette Hennighausen)

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Percy Hennighausen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 9 - 1871

8. AGE:

Years

Months

Days

If less than one day

72

2

21

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Herman Habelmann

13. Birthplace

Germany

14. Maiden Name

Maria Wuhemen

15. Birthplace

Baltimore, Md

16 (a) Informant

W. E. Wharton

(b) Address

700 W. 40th St.

17 (a) Burial

(b) Date thereof

11/1/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Lorraine

Location Woodlawn, Md.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Baltimore, Md.

19 (a)

(b)

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30

1943, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1935 to Oct 25 1943, and that I last saw him alive on Oct 25 1943.

Immediate cause of death

Congestive Myocardial Failure

Duration

1 week

Due to

Hypertensive Cardio-Vascular Disease

Many years

Due to

Other Conditions

Chronic Multiple Arteriosclerosis

8 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thomas Conrad Waff

Address

11 E. Chapel St

Date signed

10/30/43

VS 2

NOV 1 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09676

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 MO.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Baltimore
(c) City or town Garrison
(If outside city or town limits, write RURAL and give town)
(d) Street No. _____ (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

HERBERT VINCENT MARQUESS

- 3 (b) If veteran, name war PTE 3 (c) Social Security Account
No. 217 - 05 - 2546

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

- 6 (b) Name of husband or wife Ruth Hemling
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 7/27/03

8. AGE: Years 40 Months 3 Days 3 If less than one day
hr. min.

9. Birthplace Owings Mills, Maryland
(Town, county, and state)

10. Usual Occupation FOREMAN-Lasting Products

11. Industry or business

- FATHER 12. Name Edward Marquess
13. Birthplace Calvert County, Md.

- MOTHER 14. Maiden Name Grace Bailey, Bax
15. Birthplace Pennsylvania

- 16 (a) Informant Records-US Marine Hospital,
(b) Address Baltimore, Md.

- 17 (a) Burial (b) Date thereof 11/2/43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

- 18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

- 19 (a) NOV 1 1943
(b) Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1943, 3:50a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from June 29, 1943, Oct. 30, 1943, and that I last saw him alive on Oct. 30, 1943.

Immediate cause of death

Subacute bacterial endocarditis

Duration

Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy: None

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature

Address US Marine Hospital Date signed 10/30/43
Baltimore, Md.

PHYSICIAN

Underline the cause to which death should be charged statistically.

2-09677 HEALTH DEPARTMENT—CITY OF BALTIMORE G 09677

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 6300 Rappola St.)

Registered No. 161a

2-FULL NAME

(a) Residence No. 630 - S. Rappola St.

(Usual place of abode)

Ward 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred

yr.

mo.

da.

How long in U. S., if of foreign birth?

yr.

mo.

da.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M.

4-COLOR OR RACE

W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

10/21/43

7-AGE

If LESS than 1 day.

yr. mo. da.

hrs. or 10 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country).

Baltimore

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-

(Informant)

(Address)

Mrs. F. J. Greenberg 1523 Chas. St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year)

10/21/43

17-

I HEREBY CERTIFY, That I attended deceased from

10/31, 1943, to 10/21, 1943.

that I last saw him alive on

10/21, 1943.

and that death occurred, on the date stated above, at

418

The CAUSE OF DEATH* was as follows:

Asphyxia
Urban & Torrance

CONTRIBUTOR (Secondary)

(Duration) yr. mo. da.

Baby was

of Urban & Torrance

(Duration) yr. mo. da.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. H. Greenberg M.D.

10/21/43 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross A.C.

DATE OF BURIAL

11-1-43

20-UNDERTAKER

ADDRESS

Wm. S. Pielkouski 209 Eastern Ave.

NOV 1 - 1943

Huntington Williams, M.D.

G 09678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09678
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Baltimore, Maryland**
(c) Hospital or institution:
Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **25 Yrs.**

3 (a) FULL NAME

THOMAS E. CONLON

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced **Married**6 (b) Name of husband or wife **Marcella Quigley**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) **June 27, 1882**8. AGE: Years Months Days If less than one day
61 60 4 2 hr min9. Birthplace **Toledo, Ohio**
(Town, county, and state)10. Usual Occupation **General Tax Agt.**11. Industry or business **B. & O. R. R.**12. Name **Thomas Conlon**13. Birthplace **Mass.**14. Maiden Name **Catherine Voelmayer**15. Birthplace **Ohio**16 (a) Informant **Mrs. Marcella Conlon**(b) Address **3714 Woodbine Ave.**17 (a) **Burial** (b) Date thereof **11/2/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Woodlawn Cemetery**
Location **Baltimore, Md.**18 (a) Funeral director **H. W. Meyer and Son**(b) Address **805 N. Calvert St.**19 (a) **NOV 1 1943** (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.**

(b) County

Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. **3714 Woodbine Avenue**

(If rural give location)

(e) Citizen of foreign country

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Octob 29 1943** at **10:40 A.** M21. I certify that I took charge of the remains described above, held an
inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came
to **his** death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature **H. L. Wollenmeyer** M.D.Date signed **10-30-43** Ant Medical Examiner.

6 09679

HEALTH DEPARTMENT—CITY OF BALTIMORE

09679

CERTIFICATE OF DEATH

✓ 95c

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 Mc Mahon St. 2 Ward)

Registered No.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city or town where death occurred 48 m

How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

Lothie Parker

If U. S. Veteran specify WAR

(a) Residence: No. 542 Mc Mahon

St.

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX <u>Female</u>	4. Color or Race <u>Col</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Widowed</u>
6a. If married, widowed, or divorced, HUSBAND of (or) WIFE of <u>William Parker</u>		
6. DATE OF BIRTH (month, day, year) <u>Aug. 1890</u>		
7. AGE	Years <u>53</u>	Months <u>2</u>
	Days <u>—</u>	If LESS than 1 day, hrs. or min. <u>—</u>
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. <u>Domestic</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>—</u>	
	10. Date deceased last worked at this occupation (month and year) <u>—</u>	
11. Total time (years) spent in this occupation <u>—</u>		
12. BIRTHPLACE (city or town) (State or country) <u>Maryland</u>		
FATHER	13. NAME <u>Unknown</u>	
	14. BIRTHPLACE (city or town) (State or country) <u>—</u>	
MOTHER	15. MAIDEN NAME <u>Unknown</u>	
	16. BIRTHPLACE (city or town) (State or country) <u>—</u>	
17. INFORMANT (Address) <u>Carrie Sprouge</u> <u>542 Mc Mahon St</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>mt Auburn</u> Date <u>11-2-43</u>		
19. UNDERTAKER (Address) <u>George H. Nelson</u> <u>1303 Poesstman St</u>		
20. FILED Date <u>11-2-43</u>		

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 29 194322. I HEREBY CERTIFY, That Lothie Parker died on Oct. 29 1943I last saw her alive on Oct 29 1943 Death is saidto have occurred on the date stated above, at 7 P M

The principal cause of death and related causes of importance were as follows:

Organic Heart Disease

Other contributory causes of importance:

Was an operation performed? — Date of —For what disease or injury? —Name of operation Prost. ExWhat test confirmed diagnosis? — Was there an autopsy? No23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? — Date of injury — 19—Where did injury occur? — (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place —Manner of injury —Nature of injury —24. Was disease or injury in any way related to occupation of deceased? NoSigned Dr. Garland M. D.
(Address) 1534 - David Hill St

OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH ✓ 108

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Baker St. 3 Ward)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

(a) Residence: No. 515 Baker St. 3 Ward. (Usual place of abode) (If non-resident give city or town and State)

Registered No. (If death occurred in a hospital or institution, give the NAME instead of street and number.)

U.S. Veteran
Specify WAR

PERSONAL AND STATISTICAL PARTICULARS

2. SEX <u>Male</u>	4. Color or Race <u>Negro</u>	1. Single, Married, Widowed, or Divorced (write full word) <u>Married</u>
3a. If married, widowed, or divorced HUSBAND or (or) WIFE of <u>Mary Crawford</u>		
6. DATE OF BIRTH (month, day, year) <u>May 14, 1900</u>		
7. AGE <u>43 yrs</u>	Years <u>5</u>	Months <u>16</u>
8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. <u>Laborer</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>219-10-5911</u>		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (city or town) (State or country) <u>Washington D.C.</u>		
13. NAME <u>Robert Crawford</u>		
14. BIRTHPLACE (city or town) (State or country) <u>Washington D.C.</u>		
15. MAIDEN NAME <u>Jane Allen</u>		
16. BIRTHPLACE (city or town) (State or country) <u>Wash. D.C.</u>		
17. INFORMANT <u>Mary Crawford</u> (Address) <u>515 Baker St.</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>Wash. D.C.</u> Date <u>11/1</u> <u>43</u>		
19. UNDERTAKER <u>Thomas E. Nelson</u> (Address) <u>1303 Chestnut St.</u>		
20. FILED _____ 19 _____ Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) <u>Oct 30, 1943</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>Oct 27, 1942</u> to <u>Oct 30, 1943</u>
I last saw him alive on <u>Oct 29, 1943</u> Death is said to have occurred on the date stated above, at <u>1:00</u> m.
The principal cause of death and related causes of importance were as follows: <u>Tubercular Pneumonia</u>
Other contributory causes of importance: <u>none</u>
Was an operation performed? _____ Date of _____
For what disease or injury? _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____
(Signed) <u>J. P. [Signature]</u> M. D. (Address) <u>511 N. [Address]</u>

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

09681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09681

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: (a) Baltimore City, Maryland				2. USUAL RESIDENCE OF DECEASED: (a) State <u>MD</u> (b) County <u>MD</u> (c) City or town <u>Baltimore</u> (d) Street No. <u>511 W. Hoffman</u> (e) Citizen of foreign country? <u>No</u> (If yes, name country)			
(b) Street address <u>Provident Hospital</u>				(f) Length of stay in hospital or inst. (yrs., mos., or days) <u>1</u>			
(c) Hospital or institution <u>Provident Hospital</u>				(g) Length of stay in Baltimore (yrs., mos., or days) <u>53 yrs</u>			
3 (a) FULL NAME <u>Joseph Ballard</u>				3 (c) Social Security Account No. <u>1-1-1</u>			
3 (b) If veteran, name war <u>None</u>				3 (c) Social Security Account No. <u>1-1-1</u>			
4. Sex <u>Male</u>		5. Color or race <u>Colored</u>		6 (a) Single, married, widowed, or divorced <u>Married</u>			
6 (b) Name of husband or wife <u>Flora Ballard</u>				6 (c) If alive, give age <u>53</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Jan 22 - 1924</u>				8. AGE: Years <u>53</u> Months <u>9</u> Days <u>9</u> hr. <u>18</u> min. <u>00</u>			
9. Birthplace <u>Balto, Md</u>				10. Usual Occupation <u>Chauffeur</u>			
11. Industry or business <u>Chauffeur</u>				12. Name <u>John Ballard</u>			
13. Birthplace <u>Balto, Md</u>				14. Maiden Name <u>Mary Taylor</u>			
15. Birthplace <u>Balto, Md</u>				16 (a) Informant <u>Mrs Alice B. Myers</u>			
16 (b) Address <u>1046 Eden St</u>				17 (a) <u>Burial</u> (b) Date thereof <u>11-2-43</u>			
17 (c) Cemetery or crematory <u>Mt Auburn</u>				18 (a) Funeral director <u>J. L. Preston Leasing</u>			
18 (b) Address <u>579 Market St</u>				19 (a) <u>NOV 1 - 1943</u>			
19 (b) <u>Huntington</u>				20. DATE OF DEATH <u>10/31</u> 19 <u>43</u>			
21. I certify that death occurred on the date above stated that I attended deceased from <u>10/29</u> 19 <u>43</u> to <u>10/31</u> 19 <u>43</u> and that I last saw him alive on <u>10/31/43</u>				MEDICAL CERTIFICATION			
Immediate cause of death <u>Pneumonia</u>				Duration <u>2 days</u>			
Due to <u>Pneumonia</u>				Other Conditions <u>None</u>			
Date of operation <u>None</u>				Major findings of operations <u>None</u>			
of autopsy <u>None</u>				22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide				(b) Date of occurrence <u>at</u> <u>M</u>			
(c) Where did injury occur? <u>Baltimore</u> (City or town) (County) (State)				(d) Did injury occur about home, on farm, industrial place, in public place? <u>While at work?</u>			
(e) Means of injury <u>Heart</u>				23. Signature <u>J. L. Preston Leasing</u>			
Address <u>579 Market St</u>				Date signed <u>11/1/43</u>			

G 09682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09682
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color of race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Informant

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) City

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942, to Nov 1 1943 and that I last saw him alive on 10/30 1943.

Immediate cause of death

Carcinoma of rectum

Duration

2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 1 - 1943

Huntington Williams, M.D.

G 09683

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09683

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 112 N E Phail Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Baby Carol Sue Willis

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Aug 24 1949

8. AGE:

Years

Months

Days

If less than one day

27

hr.

min.

9. Birthplace

Balti Md

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

MOTHER

12. Name

Lloyd Willis

13. Birthplace

Blatensburg, Kent

14. Maiden Name

Elna Witting

15. Birthplace

Hillman Mich

16 (a) Informant

Mrs Elna Willis

(b) Address

112 N E Phail St

17 (a)

Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Ruffel Kentucky

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) 112 N E Phail St

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 112 N E Phail Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-31-1943at 8 A M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature Howard J. Urdicio M.D.

Medical Examiner.

Date signed 10/31/43

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09684

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2201 Lake avenue
(c) Hospital or institution: -----

(d) Length of stay in hospital or inst. (yrs., mos., or days) --

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Lake avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

ADAM SCHUSSLER

3 (b) If veteran, name war

3 (c) Social Security Account
No. -----

4. Sex
Male

5. Color or race
white

6 (a) Single, married, widowed, or
divorced married

6 (b) Name of husband or wife Rose P. Schussler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1864

8. AGE: Years 79 Months 9 Days 20 If less than one day
hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance Business

FATHER 12. Name Lawrence Schussler
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Austin J. Schussler

(b) Address 2201 Lake avenue

17 (a) Burial (b) Date thereof 11/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral Director Chas. J. Evans, Inc.
(b) Address 118 N. Mt. Royal Ave.

19 NOV 1 1943 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 31 1943 at M

21. I certify that death occurred on the date above stated; that I attended
deceased from Oct. 28 1943 to Oct. 31 1943.
and that I last saw him alive on Oct. 30 1943.

Immediate cause of death Out. Atherosclerosis
Hemorrhage

Due to Quile Arterio Sclerosis
Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury Mr. Gibson Porter

23. Signature 4822 Roland Ave. Date signed 11/1/43

09685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09685
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 30 1943

18 (a) Funeral director

(b) Address

19

NOV 1 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-30-43

at

M

21. I certify that death occurred on the date above stated; that I attended
deceased from 10-27-43 to 10-30-43
and that I last saw him alive on 10-27-43

Immediate cause of death

Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address University, Md

Date signed 10-30-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09686

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3026 Fellswood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3026 Fellswood Ave

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

Charles E. Dechardt

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

Margaret Dechardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1859

8. AGE:

Years

Months

Days

If less than one day

83

10

21

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

P

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

Margaret Hinkle

(b) Address

3026 Fellswood Ave

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof 11-2-43
(month) (day) (year)

(c) Cemetery or crematory

Cedar Hill

Location

18 (a) Funeral director

Leonard R. Rye

(b) Address

5305 Baltimore Rd.

19

NOV 1 - 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1943 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1943 to Oct 30 1943 and that I last saw him alive on Oct 30 1943

Immediate cause of death

Angina Pectoris

Arterio Sclerosis Coronary Artery

Due to Arterio Sclerosis Arterio Sclerosis

Due to Chronic Indurated Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Thos F. A. Stevens

Address 7878 Starford Rd Date signed 11-4-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C 09687

09687

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2333 Lauretta Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2333 Lauretta Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Catherine Born

3 (b) If veteran, name war

3 (c) Social Security Account
No. None

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced
Married

6 (b) Name of husband or wife George J. Born

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1888

8. AGE: Years

55

Months

9

Days

1

If less than one day

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

12. Name William E. Bense

13. Birthplace Baltimore, Md.

14. Maiden Name Mary Rapp

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Anna Vaughn

(b) Address 2000 Mosby Ave.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 11/2/43

(month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

Baltimore, Md.

18 (a) Funeral director Frederick J. Cole

(b) Address 100 N. Lombard St

19 (a)

NOV 1 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1943, 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943, to Oct 30 1943, and that I last saw him alive on Oct 29 1943.

Immediate cause of death

Hypertension Cardio-vascular Disease

Diagnosed Multiple Sclerosis

Due to

Other Conditions Psychosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Albert L. Lerner

1934 W. Hill

Date signed 11/7/43

G 09688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09688

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1123 Sarah Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1123 Sarah Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Salvina Benn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

D

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1943

8. AGE: Years Months Days If less than one day
54 hr. min.9. Birthplace Baltimore - MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name SALVINA BENN

13. Birthplace N.C.

14. Maiden Name VIRGINIA BENN

15. Birthplace NEWPORT NEWS-VA.

16 (a) Informant Sallie Benn

(b) Address 313 N. Schroeder Dr

17 (a) Burial (b) Date thereof 11-1-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Muskatie R. Williams

(b) Address 622 N. Schroeder Dr

19 (a) NOV 1 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1943

21. I certify that I took charge of the remains described above, held an
Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Malnutrition
(Nutritional Deficiency)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Hugh B. McHaley

Date signed 10/30/43 Medical Examiner

G 09689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09689

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 853 W University Pkwy

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

3 (a) FULL NAME

Isabella Hegner James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Norman James

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

July 25 1876

8. AGE:

Years

Months

Days

If less than one day

67

3

4

-6

hr.

min.

9. Birthplace

Washington DC

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Chas Hagner

13. Birthplace

Washington

14. Maiden Name

Isabella Louise Davis

15. Birthplace

16 (a) Informant

Howard Baetjer

(b) Address

16 W Madison St

17 (a)

Burial

(b) Date thereof

Nov 3 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London

Location

Baetjer

18 (a) Funeral director

Henry W Jenkins

(b) Address

20 E Culler Rd

19 (a)

1943

(b)

Huntington Hills, Md

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

853 University Pkwy

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1 1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1943 to Nov 1 1943, and that I last saw her alive on Nov 1 1943.

Immediate cause of death

Cerebral Hemorrhage
Right Hemiplegia

Due to

Obesity

Due to

Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Walter A Baetjer

23. Signature

Address

1155 Paul St

Date signed

11/1/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

09690

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

09690

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Union Memorial Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *12 hrs*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Marion Thomas Prout

Marian Thomas Prout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *William Leslie Prout*6 (c) If alive, give age *60* years7. Birth date of deceased (mo., day, yr.) *Jan. 15 - 1887*

8. AGE:

Years

Months

Days

If less than one day

*56**9**16*

hr.

min.

9. Birthplace *Anne Arundel County, Md.*

(Town, county, and state)

10. Usual Occupation *Housewife*11. Industry or business *At Home*12. Name *Benjamin F. Thomas*13. Birthplace *Brooklyn, Md.*14. Maiden Name *Marcellas*15. Birthplace *Anne Arundel County, Md.*16 (a) Informant *Mr. William L. Prout*(b) Address *3403 Fairview Ave.*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Nov. 2, 1943*

(month) (day) (year)

(c) Cemetery or crematory *Woodlawn Cemetery*Location *Woodlawn, Md.*18 (a) Funeral director *W. L. Amorran*(b) Address *4510 Liberty Heights Ave.*

19 (a)

(b)

(Date of registration)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3403 Fairview Ave.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-31-1943* at *8:25* AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to *her* death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Crushed Chest

Due to

Other Conditions *Fractured ribs; locomotor ataxia; and abscesses*

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *10-30-43* at *4 P.* *15/12* M.(b) Where did injury occur? *Pinkies R's near Grand Hill Park*(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *No*(d) Means of injury *To avoid collision, struck tree.*23. Signature *Thomas J. Mulderis* M.D.Date signed *10-31-43*

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 1 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G 09691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09691

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1427 W. Lanvale

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

55 years

3 (a) FULL NAME

John Abel Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

Colored

6 (a) Single, married, widowed or divorced

married

6 (b) Name of husband or wife

Mary E. Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec, 1860

8. AGE:

Years

Months

Days

If less than one day

82 83

10

hr.

min.

9. Birthplace

Dorchester Co., Md.

10. Usual Occupation

Teamster

11. Industry or business

12. Name

John Cromwell

13. Birthplace

Dorchester Co., Md.

14. Maiden Name

Sarah Enols

15. Birthplace

Dorchester Co., Md.

16 (a) Informant

Mary E. Cromwell

(b) Address

1427 W. Lanvale St

17 (a)

Burial

(b) Date thereof

Nov 3-43

(c) Cemetery or crematory

Old Field in Cambridge, Md.

18 (a) Funeral director

James A. Stamps

(b) Address

42 W. 1st St

19 (a)

Huntington Williams, M.D.

(b) Date of death

Nov 1-1943

(c) Registrar

Nov 1-1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(d) Street No.

1427 W. Lanvale

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 31, 1943, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1943, to Oct 31 1943.

and that I last saw him alive on Oct 31 1943.

Immediate cause of death

Cardiovascular renal disease

Duration

3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John E. S. Camper

Address

639 N. Carey St., Balt.

Date signed 11-1-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09692

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Effie Drake

3 (b) If veteran, name war

3 (c) Social Security Account

No. **264-104058**

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female white

Married

6 (b) Name of husband or wife

Edwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

4-13-83

8. AGE:

Years

Months

Days

If less than one day

60

6

18

hr.

min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

William Reedy

13. Birthplace

W. Va.

MOTHER

14. Maiden Name

Raney Hammond

15. Birthplace

W. Va.

16 (a) Informant

Renee

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

11/3/43

(c) Cemetery or crematory

Dorchester

Location

Cambridge Md

18 (a) Funeral director

Marjorie DeCompte

(b) Address

Cambridge Md

NOV 1 1943

(a) Date of registration

(b) Registrar
Huntington Williams, M.D.

VS 116

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

804 S. Ann St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 1 1943

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 13 1943** to **Nov 1 1943** and that I last saw her alive on **Nov 1 1943**.

Immediate cause of death **pneumonia**

Duration
3 days

Due to

colectomy

Due to

carcinoma of the colon.

2 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **Oct 11, 1943**

Major findings of operation: **Carcinoma of the colon**
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **W. Longmire Jr.**

Address **Johns Hopkins Hosp.** Date signed **11/1/43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09693
Registered No.

107

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Balchoun + Fayette Sts*

(c) Hospital or institution:

Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*

(e) Length of stay in Baltimore (yrs., mos., or days) *1 yr*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *768 W. Lexington St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Lawrence Pelczar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *4-14-40*

8. AGE: Years Months Days If less than one day

3 6 17 hr. min.

9. Birthplace

Kentucky (Town, county, and state)

10. Usual Occupation

none

11. Industry or business

12. Name *Stanley Pelczar*

13. Birthplace *Poland*

14. Maiden Name *Nolan*

15. Birthplace *Ohio*

16 (a) Informant *Stanley Pelczar*

(b) Address *768 W. Lexington St*

17 (a) *Burial* (b) Date thereof *Nov 3, 1943*

(Burial, cremation, or removal) (month-day-year)

(c) Cemetery or crematory *London Park*

Location *City*

18 (a) Funeral director *Mrs. John W. Gaudelou*

(b) Address *801 W. Fayette St*

Huntington Williams, MD

NOV 2 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-31 1943, at 11:30 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-31 1943*, to *10-31 1943*, and that I last saw him alive on *10-31 1943*.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *H. P. Friedman* M. D.

Address *1319 L St NW* Date signed

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09694

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 633 Tolna St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 633 Tolna St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Frank Persiano

3 (b) If veteran, name war

World War I

3 (c) Social Security Account

No. 213-07-2458

4. Sex

male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Clara Persiano

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2nd 1894

8. AGE: Years Months Days If less than one day

48

10

28

hr.

min.

9. Birthplace Colonnella Italy

(Town, county, and state)

10. Usual Occupation

11. Industry or business Bethlehem Steel Co.

FATHER

12. Name Luigi Persiano

13. Birthplace Italy

MOTHER

14. Maiden Name Eugenia Novella

15. Birthplace Italy

16 (a) Informant Clara Persiano (Wife)

(b) Address 633 Tolna St.

17 (a) Burial (b) Date thereof Nov. 2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Morley St.

19 NOV 2 - 1943 Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 30, 1943 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943 to Oct. 30, 1943, and that I last saw him alive on October 30, 1943.

Immediate cause of death

Cerebral Hemorrhage

Duration
Thours

Due to Arteriosclerosis

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____
While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature Phi. L. Williams

Address 2942 E. Fayette St. Date signed 10/30/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address *Redwood + Greene Sts*
(c) Hospital or institution: *University Hospital*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 day*
(e) Length of stay in Baltimore (yrs., mos., or days) *5 mo*

2. USUAL RESIDENCE OF DECEASED:
(a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1025 Malvern St*
(If rural give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country.

3 (a) FULL NAME *Margaret Wheeler*
3 (b) If veteran, name war *no* 3 (c) Social Security Account No. *—*

4 Sex *Female* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced. *Single*
(b) Name of husband or wife *none* 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1942 7/6/42*
8. AGE: Years *1* Months *5* Days *3* If less than one day hr. min.
25

9. Birthplace *Baltimore, Md*
(Town, county, and state)

10. Usual Occupation *Infant*
11. Industry or business

12. Name *Clinton Wheeler*
13. Birthplace *Charles Co. Md.*
14. Maiden Name *Francis Hooker*
15. Birthplace *Balto Md*

16 (a) Informant *Mother*
(b) Address *1025 Malvern St.*
17 (a) *Burial* (b) Date thereof *11/4/43*
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery *Lorraine*
Location *Balto Md.*

18 (a) Funeral director *William Cook Inc*
(b) Address *1217 St. Paul*
Huntington Williams, Md.
NOV 2 - 1943 (b) Registrar

20. DATE OF DEATH *10-1-43* 19 *3:55 P*
21. I certify that death occurred on the date above stated; that I attended deceased from *10-1-43* to *11-1-43* and that I last saw her alive on *11-1-43*
Immediate cause of death *Pneumonia*
Due to *infection*
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at *M*
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature *Raymond J. Kangle*
Address Date signed *10-1-43*

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09696

1. PLACE OF DEATH: Baltimore City, Maryland				2. USUAL RESIDENCE OF DECEASED: (a) State <u>MD</u> (b) County <u>Anne Arundel</u> (c) City or town <u>Severna Park</u> (d) Street No. <u>Severna Park</u> (e) Citizen of foreign country? (Yes or No) If yes, name country.			
(b) Street address (c) Hospital or institution: <u>University Hospital</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>2 yrs + 4 mo</u> (e) Length of stay in Baltimore (yrs., mos., or days)							
3 (a) FULL NAME <u>Dr. William Harry Nagengast</u>				MEDICAL CERTIFICATION			
3 (b) If veteran, name war <u>WW</u>				20. DATE OF DEATH <u>10/30</u> 19 <u>43</u> at <u>9:00 A M</u>			
3 (c) Social Security Account No. <u> </u>				21. I certify that death occurred on the date above stated; that I attended deceased from <u>10/11</u> 19 <u>43</u> to <u>10/30</u> 19 <u>43</u> , and that I last saw him alive on <u>10/30</u> 19 <u>43</u> .			
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed or divorced <u>Married</u>		Immediate cause of death <u>Coronary occlusion</u>		Duration	
6 (b) Name of husband or wife <u>Fannie May Nagengast</u>				Due to <u>Hypertensive Cardiovascular disease</u>			
6 (c) If alive, give age years				Due to <u>with type III decompensation</u>			
7. Birth date of deceased (mo., day, yr.) <u>Jan 5th 1882</u>				Other Conditions			
8. AGE: Years <u>61</u>	Months <u>9</u>	Days <u>25</u>	If less than one day <u> </u> hr. <u> </u> min.	(Include pregnancy within 3 months of death)		PHYSICIAN	
9. Birthplace <u>Balto Md.</u>				Date of operation		Underline the cause to which death should be charged statistically.	
10. Usual Occupation <u>Employed Pharmacist</u>				Major findings of operation:			
11. Industry or business <u>Severna Park Pharmacy</u>				of autopsy:			
12. Name <u>John Nagengast</u>				22. If death was due to external causes, fill in the following:			
13. Birthplace <u>Balto Md.</u>				(a) Accident, suicide, or homicide			
14. Maiden Name <u>Catherine Nummer</u>				(b) Date of occurrence <u> </u> at <u> </u> M			
15. Birthplace <u>Md.</u>				(c) Where did injury occur? (City or town) (County) (State)			
16 (a) Informant <u>W. H. Nagengast Jr</u>				(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(b) Address <u>3813 Kimble Rd</u>				(e) Means of injury			
17 (a) <u>Burial</u> (b) Date thereof <u>11/3/43</u>				23. Signature <u>David Hagan</u>		M. D.	
(c) Cemetery <u>London Park</u>				Address <u>U. Hospital</u>		Date signed <u>10/30/43</u>	
Location <u>Balto. Md.</u>							
18 (a) Funeral director <u>William Cook, Inc</u>							
(b) Address <u>1217 St. Paul St.</u>							
19 (a) <u>NOV 2 - 1943</u> (b) <u>Huntington Williams, Md.</u>							
(Date rec'd by registrar)							

09697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09697
Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address *5107 Benton Heights Ave*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *27*(e) Length of stay in Baltimore (yrs., mos., or days) *45 yrs*

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No. *11111*4 Sex *Female*5 Color *White*6 (a) Single, married, widowed, or divorced *Married*6 (b) Name of husband or wife *Andrew*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *March 3, 1861*

8. AGE:

Years *82*Months *7*Days *26*

If less than one day

hr.

min.

9. Birthplace *Germany*10. Usual Occupation *Housewife*

11. Industry or business

12. Name *Unknown*

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant *Edward Kraft*(b) Address *5107 Benton Heights Ave*17 (a) *Burial*(b) Date thereof *11/2/43*

(Burial, cremation, or removal)

(c) Cemetery or crematory *Salem Lutheran Church*Location *Catonsville, Md.*18 (a) Funeral director *William Cook Inc*

NOV 2 1943

19 (a)

(Date rec'd by registrar)

(b) *Huntington, Williams, Md.*

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *5107 Benton Heights Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 29 1943, 2:30 M*21. I certify that death occurred on the date above stated; that I attended deceased from *Sept 1 1943* to *Oct 29 1943* and that I last saw *her* alive on *Oct 28 1943*.

Immediate cause of death

Due to

Due to

Other Conditions *Arterio Sclerosis*

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at *M*

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Charles A. Anderson*Address *3001 Shannon*

Date signed

M. D.

Done Oct. 30-43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09698

AB 22813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09698

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

3 Months-7 Days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) St. Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Myrtle Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sadie Otho

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 29-1884

8. AGE: Years

59

Months

2

Days

1

If less than one day

hr.

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Thomas Kennard

13. Birthplace Md.

14. Maiden Name Rachel Esker

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (b) Date thereof 11-3-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Lettier Gross

(b) Address 1408 Ashland ave

19 (a) (Date registered) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 30 1943 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30-1943 to 10-30-1943, and that I last saw her alive on 10-30-1943.

Immediate cause of death

Pulmonary Infarct

Due to

FAC embolism

Due to Hypertensive cardio

vascular disease with de

Other Conditions compensation

Atrophy of Left Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: No change

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Mattman

Address B. C. H.

Date signed 10/30/43

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 2 - 1943

09699

ID - 82667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09699
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 4940 Eastern Ave.
 (c) Hospital or institution: Baltimore City Hospitals
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 13
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2012 Gough St.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME Barbara Williams

3 (b) If veteran, name war

3 (c) Social Security Account
No. 218-056724

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1881

8. AGE: Years 62 Months 8 Days 1 If less than one day hr min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Fred Thierrouj
 13. Birthplace Germany
 14. Maiden Name Anna Schmidt
 15. Birthplace Germany

16 (a) Informant B. C. H. Records
 (b) Address

17 (a) B. (b) Date thereof 11-3-43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory National Cem
 Location Frederick, Md.

18 (a) Funeral director John J. Quola
 (b) Address 2829 H. Hudson St

NOV 2 - 1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1943 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attend-
 ed deceased from 7-16-1943, to 10-29-1943,
 and that I last saw him alive on 10-29-1943.

Immediate cause of death

Due to Carcinoma of Uterus
 with metastases

Due to Risk vaginal fistula
 & hydrocephalus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
 place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Donald B. White

Address 2012 Gough St Date signed 10-30-43

Duration

1 yr 4
 6 mo 5
 6 mo 5

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G 09700

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 LOUISE AVENUE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Miss Ethel Harkins

3 (b) If veteran, name war

☒

3 (c) Social Security Account

No. 216-10-6420

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 9, 1876

8. AGE: Years Months Days If less than one day

47 6 22 hr. 18 min.

9. Birthplace

Balds, Md.

10. Usual Occupation

Cashier - O'Keefe Store

11. Industry or business

Dry Goods

12. Name

Richard H. Harkins

13. Birthplace

Md.

14. Maiden Name

Sallie H. Hood

15. Birthplace

Md.

16 (a) Informant

Mrs. M. H. Harkins

(b) Address

Valmont Creek Cal.

17 (a) Burial

(b) Date thereof Nov 8/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium

London Park

Location

3801 Fred. Ave.

18 (a) Funeral director

John O. Mitchell

(b) Address

1900 Eutaw Place

19 (a)

(b) Huntington Williams, Md.

Nov 2 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1943 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1943 to 11-1 1943, and that I last saw him alive on 11-1 1943.

Immediate cause of death

Metastatic Carcinoma

Due to Carcinoma of left Breast.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Stanley B. Kujawski

Date signed 11-1-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09701

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *N. Broadway*

(c) Hospital or institution:

Church Home and Hospital

(d) Length of stay in hospital or inst. (yrs., mos., weeks) *4 1/2*

(e) Length of stay in Baltimore (yrs., mos., or days) *1 1/2*

3 (a) FULL NAME

Miss Rosa Wallach

3 (b) If veteran, name war

☒

3 (c) Social Security Account

No. ☒

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age *5* years

7. Birth date of deceased (mo., day, yr.)

June 6, 1891

8. AGE:

Years

Months

Days

If less than one day

84

4

25

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

None

retired

11. Industry or business

FATHER

MOTHER

12. Name

John Wallach

Wallach

13. Birthplace

Washington D.C.

14. Maiden Name

Margaret

Newton

15. Birthplace

Virginia

16 (a) Informant

George R. Wallach

(b) Address

2308 Brooklyn Ave

17 (a)

Burial

(b) Date thereof

Nov. 2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

Frederick Ave

18 (a) Funeral director

John O. Mitchell

(b) Address

1200 Potomac Place

19 (a)

NOV 2 1943

(Date rec'd by registrar)

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

N. Broadway

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 31

19 *43* at *4:15* A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *July 1, 1942* 19 *42* to *Oct. 31* 19 *43*, and that I last saw him alive on *Oct. 30* 19 *43*.

Immediate cause of death

Obstruction of breast

Duration

3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

[Signature]

Address

Arch St & Hospital

Date signed

10/31/43

G 09702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09702

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 2211 Chelsea Terrace

(c) Hospital or institution:

none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Chelsea Terrace

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME

Lucy Lee Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
female5. Color or race
white6 (a) Single, married, widowed, or divorced
single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1873

8. AGE: Years Months Days If less than one day
70 9 15 hr. min.

9. Birthplace RUFF Portsmouth, Va.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Joseph C. Brown

13. Birthplace Va.

14. Maiden Name Olivia Owen

15. Birthplace Va.

16 (a) Informant Mrs. Leonard Rea

(b) Address 2211 Chelsea Terrace

17 (a) Burial (b) Date thereof 11/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery ~~concord~~ Lorraine

Location Windsor Mill Road, Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Rutaw Place

19 (a) NOV 2 - 1943

(Date rec'd by registrar)

Registrar

VB 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1943 to Oct. 31 1943, and that I last saw him alive on Oct. 31, 1943.

Immediate cause of death

Acute Cardiac Disturbance

Due to

arterio sclerosis.

Due to

Hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John C. Blake

Address Med. Arts Bldg.

Date signed

M. D.

Blake

Duration

2 de.

several years.

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09703

Registered No. G 09703

1. PLACE OF DEATH:
Baltimore City, Maryland
Street address 3625 Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Margaret M. Manus
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widow
6 (b) Name of husband or wife Late Martin M. Manus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1871
8. AGE: Years 72. Months 16 Days 16 If less than one day hr. min.
9. Birthplace Petersburg, Va.
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business of home

12. Name Alexander Lindsay
13. Birthplace Scotland
14. Maiden Name Euphemia Stuart
15. Birthplace Scotland

16 (a) Informant Mr Charles E. M. Manus
(b) Address 3625 Belvedere Ave
17 (a) burial (b) Date thereof 11/3/43
(month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Baltimore, Md.
18 (a) Funeral directors J. J. Conway & Son
(b) Address 901 E. Illinois Street
19 (a) NOV 2 1943 (b) Hunting for Williams

20. DATE OF DEATH 10/31 1943 at 6:30 A.M.
21. I certify that death occurred on the date above stated, that I attended deceased from Oct 20th 1943 to Oct 30th 1943 and that I last saw her alive on Oct 29 1943.
Immediate cause of death
Hypertensive Cerebral Hemorrhage
Due to
Cerebral Hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place) (Specify type of place) While at work?
(e) Means of injury
23. Signature Alex A. Vennstock
Address 4603 P K Moore Date signed 10/31/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09704
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3319 Shelburne Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

CORA VIRGINIA JONES

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Harry A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1869

8. AGE: Years Months Days If less than one day
74 7 24 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph Underwood

13. Birthplace Balto., Md.

14. Maiden Name Elizabeth Sweitzer

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ethel Nugent

(b) Address 3319 Shelburne Rd.

17 (a) Burial (b) Date thereof 11/2/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a)

NOV 2 - 1943
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Shelburne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1943 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1943 to 10/30 1943 and that I last saw her alive on 10/30/43.

Immediate cause of death

Cerebral Hemorrhage.

Due to

Hypertension

Due to

Other Conditions

Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

James A. Kille
Pikesville, Md. Date signed 11/2/43

Duration

9/10/93

3 yrs

17

PHYSICIAN

Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 09705

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address Charles & Franklin St.,
(c) Hospital or institution: Roohanbeau Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Franklin Sts.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY RICHARDSON SNOWDEN

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. none

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1854

8. AGE: Years Months Days If less than one day
89 7 18 16 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Thomas Snowden

13. Birthplace South River, Md.

MOTHER 14. Maiden Name Maria L. Schwar

15. Birthplace --

16 (a) Informant Mr. Wilton Snowden, Jr.

(b) Address 12 E. 33rd St. - Apt. 2C

17 (a) Burial (b) Date thereof 11/2/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) 11/2/43 Williams, M.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1943, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19/43 to Oct. 31, 1943 and that I last saw her alive on Oct. 29, 1943.

Immediate cause of death

Myocarditis.
Arterio-sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 1402 Park Ave Date signed 11/2/43

Duration

Gradual

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 140 NOV 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09706

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No. 247-36-453

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 1943

1943

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G 09707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09707
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1514 Madison Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HELEN COOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 1, 1911

8. AGE: Years Months Days If less than one day

31 33 10 28 hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

waitress

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden Name

Unknown

15. Birthplace

Unknown

16 (a) Informant

(b) Address

John L. Cook
3918 Gm. Service Co. Building

NOV 4 1943

(b) Date thereof

NOV 2 1943

(c) Cemetery or crematory

Location

St. Calvary

18 (a) Funeral director

(b) Address

Adolphus H. Hester
294 E. Pratt St.

NOV 2 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1514 Madison Avenue

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

6 P.

20. DATE OF DEATH October 29, 1943, at M

21. I certify that I took charge of the remains described above, held an

Inspection

thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐,

homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Syphilis cardiovascular.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature H. W. Wallenmeyer

M.D.

Date signed 10-30-43

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09708

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

G 09708

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME

Joseph Widgeon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1863

8. AGE:

Years

Months

Days

If less than one day

80329

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

Unemployed

11. Industry or business

FATHER
MOTHER12. Name Solomon13. Birthplace Va14. Maiden Name Susan15. Birthplace ?16 (a) Informant B. C. H. Records

(b) Address

4940 Eastern

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year) Nov 2, 1943

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

NOV 2 - 1943

(Date signed by registrar)

Montgomery Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/281943at 4:35 A

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1943, to 10/28 1943, and that I last saw him alive on 10/28 1943.

Immediate cause of death

Cerebral
hem. in thrombosis;
post. embolus;
Due to A-S. CV. disease

Due to

Other Conditions

Latent
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

Heart coronary is held in
post. mass. embolus, it
of autopsy confirmed same.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

S. L. Sigmans
BCH 10/30

Duration

8 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09709

Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address *Calvert & Saratoga*
(c) Hospital or institution: *Mercy Hoop*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *22 days*
(e) Length of stay in Baltimore (yrs., mos., or days) *30 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1015 N. Belmont St*
(If rural give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country

3 (a) FULL NAME *Cecelia Lockley*
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *B* 6 (a) Single, married, widowed, or divorced *M*

6 (b) Name of husband or wife *James Thomas Lockley*
(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) *Aug 11, 1894*

8. AGE: Years *49* Months *2* Days *18* If less than one day hr. min.

9. Birthplace *Va.*
(Town, county, and state)

10. Usual Occupation *Domestic*

11. Industry or business

12. Name *James Carey*
13. Birthplace *Va.*

14. Maiden Name *Eliza Harris*
15. Birthplace *Va.*

16 (a) Informant *Grace Norman*
(b) Address *660 W. Mulberry St*

17 (a) *Burial* (b) Date thereof *Nov 2, 1943*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Zion Cem.*
Location

18 (a) Funeral director *Mr. Kate R. Williams*
(b) Address *322 N. Broadway St*

19 (a) *NOV 2 - 1943* (b) *Huntington Williams, M.D.*
(Date signed by) (Signature)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 29* 19 *43* at *5 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 7* 19 *43* to *Oct 29* 19 *43*, and that I last saw her alive on *Oct 29* 19 *43*.

Immediate cause of death

Respiratory Failure

Due to *Pneumococcal*
Pneumonia (no type)

Due to *Tuberculosis*
(Pulmonary)

Other Conditions *Albuminuria*
Hematuria

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Robert B. Turner*
Address *Mercy Hoop* Date signed *11/28/43*

Duration

4 hrs

1

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-54396

G 09710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09710

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1829 Vine St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Nannie Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1883

8. AGE:

Years

Months

Days

If less than one day

60

6

20

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Claybourn Ghee (D)

13. Birthplace Va. ?

14. Maiden Name Sarah Hazelwood (D)

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address

Records

17 (a)

Burial

(b) Date thereof

Nov. 2, 1943

(Burial, cremation, or removal)

(month, day, year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

322 N. Hollister St.

NOV 2 - 1943

(b)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1943 at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1943 to 10-28 1943 and that I last saw him alive on 10-28 1943.

Immediate cause of death

Terminal pneumonia 4 days

Duration

Left knee arthritis 16 weeks

Duration

Toxic exanthema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul Madson

Address

P.C.H.

Date signed

M.D.

10/29/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09711
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Nichols and Cator ques.*
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) *7 days*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *322 N. Lorraine Ave.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

John Brocato
3 (b) If veteran, name war *WORLD WAR - 1*
3 (c) Social Security Account No.

4. Sex *Male* 5. Color or race *White* 6 (a) Single, married, widowed, or divorced *Married*
6 (b) Name of husband or wife *Margaret A.*
6 (c) If alive, give age *45* years

7. Birth date of deceased (mo., day, yr.) *Nov 6, 1895*

8. AGE: Years *47* Months *11* Days *25* If less than one day
hr. min.

9. Birthplace *Italy*
(Town, county, and state)10. Usual Occupation *Shoe Repairing*

11. Industry or business

12. Name *Joseph Brocato*13. Birthplace *Italy*14. Maiden Name *Theberia Fatite*15. Birthplace *Italy*16 (a) Informant *Margaret A. Brocato*(b) Address *322 W. Lorraine Ave.*17 (a) *Burial* (b) Date thereof *Nov 3/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Holy Redeemer*
Location *Belair Road*18 (a) Funeral director *Chenoweth & Donovan*(b) Address *3615 17th Street Ave*

19 (a) (b) Registrar

VH 114

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 31 1943* *10:30 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 24 1943* to *Oct 31 1943* and that I last saw him alive on *Oct 31 1943*.

Immediate cause of death *Generalized peritonitis*
Due to *Post Op. Infection*
Due to *Cholecystitis*

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation *10-23-43*
Major findings of operation *Cholelithiasis*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *W. J. Brown*Address *St. Agnes Hosp.* Date signed *11-21-43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09712

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

G 09712

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **Wyman Park Drive & 31st St.**

(c) Hospital or institution:

U. S. Marine Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) **16 days**(e) Length of stay in Baltimore (yrs., mos., or days) **16 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.**(b) County **Harford**(c) City or town **Forest Hill**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **-**

(If rural give location)

(e) Citizen of foreign country? **No**

(Yes or No)

If yes, name country

3 (a) FULL NAME **WM. HENRY JONES**

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No. **-**

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. **Married**6 (b) Name of husband or wife **Margaret F. Cockran**6 (c) If alive, give age **42** years7. Birth date of deceased (mo., day, yr.) **Jan. 20, 1896**

8. AGE: Years

47

Months

9

Days

12

If less than one day

11 hr.

min.

9. Birthplace **Harford County, Maryland**

(Town, county, and state)

10. Usual Occupation **Carpenter**11. Industry or business **Edgewood Arsenal**

FATHER

12. Name **George Jones**13. Birthplace **Harford County**

MOTHER

14. Maiden Name **Frances Peterson**15. Birthplace **Harford County**16 (a) Informant **Records, U.S. Marine Hosp.**(b) Address **Baltimore, Maryland**17 (a) **Burial** (b) Date thereof **11-4-43**

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location **St. Ignace**18 (a) Funeral director **Chas. E. Gross**(b) Address **Benson, Md.**19 (a) **NOV 2 - 1943** (b)

(Date rec'd by registrar)

Huntington, Md. - 13856

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **November 1, 1943** at **2:50 M**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 16, 1943** to **Nov. 1, 1943**, and that I last saw him alive on **Nov. 1, 1943**.Immediate cause of death **Chronic Glomerular nephritis; & Uremia**Duration **Unk.**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: **as above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**

(Specify type of place)

(e) Means of injury

23. Signature **John B. Holt**Address **Baltimore, Md.**Date signed **11/2/43**

13

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09713

Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address **Wyman Park Drive & 31st St.**
- (c) Hospital or institution:
U. S. Marine Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) **8 days**
- (e) Length of stay in Baltimore (yrs., mos., or days) **2 years**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
- (c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
- (d) Street No. **1602 McCulloch Street**
(If rural give location)
- (e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME **JACK LOUDERMILK**

- 3 (b) If veteran, name war **World's War**
- 3 (c) Social Security Account No.

4. Sex **Male**
5. Color or race **Col.**
- 6 (a) Single, married, widowed, or divorced **Single**

- 6 (b) Name of husband or wife
- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 6, 1895**

8. AGE: Years **48** Months **4** Days **25**
If less than one day hr. min.

9. Birthplace **Madison, Wisc.**
(Town, county, and state)

10. Usual Occupation **Westinghouse-3 days prior**

11. Industry or business **to 10/23/43**

- FATHER 12. Name **George Loudermilk**
13. Birthplace **British W. Indies**

- MOTHER 14. Maiden Name **Rose Deadman**
15. Birthplace **British W. Indies**

- 16 (a) Informant **Records, U.S. Marine Hospital**
- (b) Address **Baltimore, Md.**

- 17 (a) **Burial** (b) Date thereof **Nov. 8, 1943**
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory
Location **Greencastle, Arkansas**

- 18 (a) Funeral director **Mrs. George H. Holland**

- (b) Address **31 Duval St. One.**
- (c) **Huntington Williams, M.D.**

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 31, 1943** at **8:50 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 23, 1943** to **Oct. 31, 1943** and that I last saw him alive on **Oct. 31, 1943**.

Immediate cause of death **Hypertensive
cardio Vascular Disease with
failure and uremia**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operation:

of autopsy: **None**

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide **No**

- (b) Date of occurrence at **M**

- (c) Where did injury occur?
(City or town) (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature **J. C. Mchen**Address **Baltimore, Md.**Date signed **11/1/43**

Va-13886

Duration
Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09714

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD

(b) County Charles

(c) City or town

Dentonsville

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Annie Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1922

8. AGE:

Years

Months

Days

If less than one day

21

hr.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name

Walter S. Miller

13. Birthplace

Chesapeake Falls, Wis.

MOTHER

14. Maiden Name

Laura C. Miller

15. Birthplace

Dentonsville, Md.

16 (a) Informant

Walter S. Miller

(b) Address

Dentonsville Md

17 (a)

Removal

(b) Date thereof

Nov 3, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Washington D.C.

18 (a) Funeral director

Deal Funeral Home

(b) Address

4812 Hc Ave NW Wash DC

19 (a)

(b)

(Date rec'd by registrar)

Registrar

NOV 2 - 1943

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/2

19 43

at 3:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/11 19 43, to 11/2 19 43, and that I last saw him alive on 19

Immediate cause of death

Sepsis

Duration

Due to

Criminal Abortion?

Due to

Generalized peritonitis

Due to

Empyema - Abortion

Other Conditions

Healed Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. Cohen

Address

Univ. Hosp

Date signed

11/2/43

09715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09715
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date of death

(c) Registered

(d) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/31/

1943

at 8:43 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 3, 1943, to October 31, 1943, and that I last saw him alive on October 31, 1943.

Immediate cause of death

Cardio Respiratory Failure

Due to

Hypostatic Pneumonia

Due to

Encephalitis diffuse

Other Conditions

Decubitus ulcers

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy: meningocystitis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully suggested. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 2 1943

VB 154

G 09716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09716

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4600 Park Heights Ave

(c) Hospital or institution:

Mt Sinai Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Balti

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1520 Laurens St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Helen Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Hymon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1898

8. AGE:

Years

Months

Days

If less than one day

55

hr.

min.

9. Birthplace

Lith.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Mayer

13. Birthplace

Lith.

14. Maiden Name

Ester

15. Birthplace

Lith.

16 (a) Informant

Family Records

(b) Address

17 (a)

Buried

(b) Date thereof

11-2-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

North St. & German Hill Rd

Location

same

18 (a) Funeral director

Jack Lewis Inc

(b) Address

1439 E Balto St

19 (a)

NOV 2 1943Huntington Williams, MD

VB 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1943 at 11:57 PM21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1943 to Nov. 1 1943, and that I last saw him alive on Nov. 1 1943.

Immediate cause of death

Cerebral Hemorrhage
Cathexis
& Hemiplegia
Due to Hypertension

Duration

31 month1

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Harry Ashman MDAddress 1921 W North Ave. Date signed 11/2/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09717
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State 2205 (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Greenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Morris Greenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887
8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Rayn-
13. Birthplace Russia

MOTHER 14. Maiden Name
15. Birthplace Russia

16 (a) Informant Morris Greenberg
(b) Address 1531 N. Payson St

17 (a) Burial (b) Date thereof 11-2-43 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Pereira Inc
(b) Address 1439 E. Balt.

19 (a) NOV 27 1943 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-43 19 at 4A M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21, 1943, to Nov. 2, 1943, and that I last saw him alive on Nov. 2, 1943.

Immediate cause of death
Cardiac Failure
Pulmonary Edema
Due to Chronic Myocarditis
Arteriosclerosis

Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury
23. Signature Philip F. Lerner, M.D.
Address 2401 N. North Ave. Date signed 11/2/43

Duration 10 hr
?
1
PHYSICIAN
Underline the name to which death should be charged statistically.

PHILIP F. LERNER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09718

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 1400 - N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

- (a) City or town Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Lakeshore Ave #18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY GIRL COOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9 Years 2 Months 4 Days min.
9 Years 2 Months 4 Days

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name William J. Cook

13. Birthplace Joppa, Md.

14. Maiden Name Josephine Harrison

15. Birthplace Vinal Island, Md.

16 (a) Informant J. B. Ballena

(b) Address 625 Lakeshore Ave #18

17 (a) Burial (b) Date thereof 11 2 1943

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Mary M. Wedgwood

(b) Address 501 E. 22nd St.

19 (a) Date 1943

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 1 1943 at 12 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 12 1943 to 11 1 1943, and that I last saw him alive on 11 1 1943.

Immediate cause of death

Cholera

Due to

Due to

Other Conditions

Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

J. B. Ballena

Address

St. Joseph's Hospital

M. D.

11/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09719
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1605 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

EDWARD A. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife Julia Tilghman Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/1862

8. AGE: Years 81 Months 6 Days 17
If less than one day
hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business Self

12. Name Henry Smith

13. Birthplace Loudon, England

14. Maiden Name Josephine V. Tillyard

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Julia Smith

(b) Address 1605 W. North Ave.

17 (a) Burial (b) Date thereof 11/3/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1943, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/1/42 to 11/1/43, and that I last saw him alive on 10/26/43.

Immediate cause of death
Chronic Myocarditis +
Aortic Sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

1943 Wm J Tickner Date signed 11/2/43

Houck

NOV 2 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The subject's age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		G 09720	
CERTIFICATE OF DEATH		Registered No.	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <i>N. Broadway</i> (c) Hospital or institution: <i>Church Home and Hospital</i> (d) Length of stay in hospital or inst. (yrs., mos., or days) <i>12</i> (e) Length of stay in Baltimore (yrs., mos., or days)		2. USUAL RESIDENCE OF DECEASED: (a) State <i>Md.</i> (b) County (c) City or town <i>Baltimore</i> (If outside city or town limits, write RURAL and give town) (d) Street No. <i>2421 N. Calvert Street</i> (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country.	
3 (a) FULL NAME <i>Mrs Ruth Allison</i>			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex <i>F</i>	5. Color or race <i>W</i>	6 (a) Single, married, widowed, or divorced. <i>W</i>	
6 (b) Name of husband or wife			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <i>August 14, 1878</i>			
8. AGE: Years <i>65</i> Months <i>2</i> Days <i>17</i> If less than one day hr. min.			
9. Birthplace <i>Cambridge, Md.</i> (Town, county, and state)			
10. Usual Occupation <i>None</i>			
11. Industry or business			
12. Name <i>George Maxwell</i>			
13. Birthplace <i>Delaware</i>			
14. Maiden Name <i>Lillie Hubbard</i>			
15. Birthplace <i>Wagons</i>			
16 (a) Informant <i>Hospital Records</i>			
(b) Address			
17 (a) <i>Burial</i> (b) Date thereof <i>11/3/43</i> (Burial, cremation, or removal) (month) (day) (year)			
(c) Cemetery or crematory <i>Greenmount</i> Location <i>Wagons, Md.</i>			
18 (a) Funeral director <i>Wm. J. Tidner & Sons</i>			
(b) Address <i>Balto., Md.</i>			
(c) <i>1943</i> (d) <i>1943</i> (Date of death) (Date of registration)			
20. DATE OF DEATH <i>October 31, 1943</i> at <i>3:45</i> P.M.			
21. I certify that death occurred on the date above stated; that I attended deceased from <i>10/27 1943</i> to <i>10/31 1943</i> , and that I last saw h. <i>CC</i> alive on <i>10/31 1943</i> .			
Immediate cause of death <i>Uremia</i>			
Due to <i>Acute glomerulonephritis</i>			
Due to			
Other Conditions <i>Acute glomerulonephritis and Adenitis</i> (Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy <i>Same</i>			
22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence at <i>M</i> (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? (e) Means of injury			
23. Signature <i>W. Goldberg</i> Address <i>Church Home & Hospital</i> Date signed <i>10/31/43</i>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09721
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caton & Wilkens Ave*

(c) Hospital or institution:

St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *9 d.*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3217 Wilkens Road*

(If rural give location)

(e) Citizen of foreign country? *no* (Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Bertha Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife *Wm. J.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan. 28, 1875*

8. AGE:

Years

Months

Days

If less than one day

68

9

3

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

housewife

11. Industry or business

12. Name

Otho Selby

13. Birthplace

Howard Co., Md.

14. Maiden Name

Jennie Feagans

15. Birthplace

W. Va.

16 (a) Informant *Mrs. Mable Ackman*

(b) Address *326 W. Chocolate Ave. HERSHEY, Pa.*

17 (a) *burial* (b) Date thereof *11/3/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Silverbrook*

Location *Wilkesboro, N.C.*

18 (a) Funeral director *Wm. J. Tietner & Sons*

(b) Address *Balto., Md.*

19 (a) (b)

(Date rec'd by registrar)

NOV 2 1943

Huntington

Williams

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-31 1943* at *10:15 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *10-23 1943* to *10-31 1943*, and that I last saw her alive on *10-31 1943*.

Immediate cause of death

Cerebral Hemorrhage

Duration

9 d.

Due to *Hypertensive, cardio vascular disease*

Due to

Other Conditions

none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

none

of autopsy

none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature *Howard W. Stier*

Address *St Agnes Hosp.* Date signed *10/31/43*

G 09723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09723
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1906 E Lammale St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Balto(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1906 E Lammale
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Elizabeth Dodd

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Rev. Dr. H. H. Dodd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26, 1868

8. AGE:

Years 75Months 7Days 5

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER
MOTHER12. Name Christian Scoll13. Birthplace Balto14. Maiden Name Louise Roden15. Birthplace Balto16 (a) Informant Mrs. Aug. Krider(b) Address 1906 E Lammale St17 (a) Interment (b) Date thereof Nov 2nd
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Lorraine Park
Location Balto18 (a) Funeral director Ulrich Funeral Home(b) Address 2018 E Lammale St

NOV 2 1943 (b)

VB 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1943, at 7:30 P M21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1941, to Oct 31 1943 and that I last saw him alive on Oct. 31 1943.

Immediate cause of death

Acute Cardiac Failure

Due to

Arteriosclerosis

Due to

Degenerative Myo-Carditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. P. ValentiniAddress 1732 Broadway Date signed 11/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09724

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09724

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

326 S. Smallwood St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

326 S. Smallwood St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Pophie H. Zimmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 1, 1880

8. AGE:

Years

Months

Days

If less than one day

63

- 4

- 0

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Laundry Business

11. Industry or business

Laundry Route

FATHER
MOTHER

12. Name

John C. Zimmerman

13. Birthplace

Batto. Md

14. Maiden Name

Susan Frances Askey

15. Birthplace

Batto. Md

16 (a) Informant

Mr John O. Zimmerman

(b) Address

6390 Frederick Rd

17 (a)

Burial

(b) Date thereof

Nov 3-1943

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood Cemetery

Location

Taylor Ave Balto. Md

18 (a) Funeral director

Milton Schelling

(b) Address

3914 S. Hanover St.

19 (a)

NOV 2 - 1943

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1943

at

M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943, to Nov 1943, and that I last saw him alive on Oct 25 1943.

Immediate cause of death

Personal
Accident (falling) while
returning home from work

Duration

Due to

Due to

Other Conditions

Pulmonary Disease

(Include pregnancy within 1 month of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. H. Williams

Address

457 W. 10th St.

Date signed

11/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09725

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09725

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 343 S. Fulton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Elizabeth M. Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

late John Woods

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 19, 1865

8. AGE: Years

78

Months

1

Days

11

If less than one day

hr.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John Scanlon

13. Birthplace

Ireland

14. Maiden Name

Catherine McElroy

15. Birthplace

Ireland

16 (a) Informant

Mrs. Marie Bradford

(b) Address

343 S. Fulton Ave.

17 (a) Burial

(b) Date thereof Nov 3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

Harry H. Witzke

(b) Address

41016 Edmondson Ave.

NOV 2 - 1943

(b) Huntington Williams, Md.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

343 S. Fulton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30

1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from April, 1943, to Oct 30, 1943.

and that I last saw her alive on Oct 30, 1943.

Immediate cause of death

Pulmonary Edema

Due to

Bronchopneumonia

Due to

Cerebral Hemorrhage

Other Conditions

Hypertension

Chronic Nephritis

Diabetes

Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Hermon H. Bayless

Address 1600 Wilkes Ave

Date signed 11/2/43

PLEASE WRITE PRINTED, WITH CONFIDENCE. Every item of information should be clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09726

Registered No. 1131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1934 W. Lafayette Ave.
(c) Hospital or institution: Mrs. Sec. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 W. Lafayette Ave. (Room) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

John Porcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1877

8. AGE:

Years 66

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual Occupation

Bar Tender

11. Industry or business

Norman Clark

FATHER
MOTHER

12. Name

August Porcher

13. Birthplace

Germany

14. Maiden Name

Wolf

15. Birthplace

Germany

16 (a) Informant

Mrs Anna W. Readmond

(b) Address

300 E 35th St

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Nov. 3/43
(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

Baltimore Maryland

18 (a) Funeral director

Haggen St. White

(b) Address

NOV 2 - 1943

19 (a)

NOV 2 - 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-1943 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cardio-vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.

23. Signature Howard J. Maldeio

M.D.

Medical Examiner.

Date signed 11/6/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT		G 09727	
CERTIFICATE OF DEATH		Registered No.	
1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address 4940 Eastern Ave. (c) Hospital or institution: BALTIMORE CITY HOSPITALS (d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs., 9 mos., 24 days 13 (e) Length of stay in Baltimore (yrs., mos., or days) life		2. USUAL RESIDENCE OF DECEASED: (a) State Maryland (b) County (c) City or town Baltimore (If outside city or town limits, write RURAL and give town) (d) Street No. 836 Power St. (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country	
3 (a) FULL NAME Lottie Riley			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex Female	5. Color or race White	6 (a) Single, married, widowed, or divorced Widowed	
6 (b) Name of husband or wife			
6 (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) 1870 ?			
8. AGE: Years 73?	Months ?	Days ?	If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)			
10. Usual Occupation Housewife			
11. Industry or business			
12. Name ?			
13. Birthplace ?			
14. Maiden Name ?			
15. Birthplace ?			
16 (a) Informant BALTIMORE CITY HOSPITALS			
(b) Address (RECORDS)			
17 (a) Burial (b) Date thereof 11-4-43 (month, day, year)			
(c) Cemetery or crematory Friedland			
Location Baltimore Md			
18 (a) Funeral director Chas. B. Cross			
(b) Address Benson, Md.			
NOV 2 - 1943 (b) Registrar			
VS 150 Huntington Williams, M.D.			
MEDICAL CERTIFICATION			
20. DATE OF DEATH 11/2 1943 at 7:45 AM			
21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1943 to 11/2 1943. and that I last saw her alive on 11/2 1943.			
Immediate cause of death			
Pneumonia			
Due to			
Due to			
Other Conditions Old rt. hemiplegia; am. arteriosclerosis (Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operations			
of autopsy: no post			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(e) Means of injury			
23. Signature E. I. Sengman			
Address B C H Date signed 11/2			

44306+

G 09728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09728
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) **35 yrs**

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female Black

5. Color or race

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-18-92

8. AGE:

Years

41

Months

5

Days

13

If less than one day

hr. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

William Anderson

13. Birthplace

MD

14. Maiden Name

Mary

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

10-3-43

(c) Cemetery or crematory

Mt. Calvary

Location

A. A. Co

18 (a) Funeral director

Rayner Sanders

(b) Address

1412 E. Preston St

19 (a)

NOV 2 - 1943

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

MD

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

713 N. Dallas St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 31 1943 at 4 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 18 1943** to **Oct 31 1943** and that I last saw him alive on **Oct 31 1943**

Immediate cause of death

Cerebral Thrombosis

Due to

Arteriosclerosis

Due to

Hypertension

Other Conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

John R. Birmingham

Address

J. H. H

Date signed

11-1

Duration

13 days**10 years****10 years****10 years**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09729

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 919 N. Caroline St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 919 N. Caroline St
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

William H. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years Months Days If less than one day

57 56 6 16 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Thomas Jones

13. Birthplace Lancaster Va

14. Maiden Name Ella Siegal

15. Birthplace Lancaster Va

16 (a) Informant Lillian M. Jones

(b) Address 919 N. Caroline St

17 (a) Burial (b) Date thereof 11/14/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Arbutus Mini Park
Location Baltimore Md

18 (a) Funeral director Mrs Ida Bayley

(b) Address 1421 Jefferson St

19 (a) Date rec'd by Registrar 11/14/43
Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1943 to Oct 31 1943, and that I last saw him alive on Oct 31 1943.

Immediate cause of death.

Pulmonary tuberculosis
Due to

Due to

Other Conditions Cardiac-renal

Injury
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Albert L. Refarow

Address 822 N. Bond St Date signed 11/14/43

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV

VS 1

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

730

AB

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09730
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. 7 yr. 3 mos. 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. No Home

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

George Nelson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-1858

8. AGE: Years Months Days If less than one day

85

?

?

hr

min

9. Birthplace Baltimore, Md

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

12. Name Martin Nelson

13. Birthplace Baltimore, Md.

14. Maiden Name Margaret ?

15. Birthplace Baltimore, Md

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL NOV 2 1943

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 2 - 1943 Huntington Williams, M.D.

VS 110

10480

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1943 at 2:00 A

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 10/25 1943
and that I last saw him alive on 10/25 1943.

Immediate cause of death

Undetermined
Diss. coronary thrombosis
Due to A-S. C.V. disease

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

E. L. Sargian
BCH

Date signed 11/1/43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

09731

AB-84478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09731

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days)

7 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1425 Lanvale St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Baby Boy Siler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10/22/43

8. AGE:

Years

Months

Days

If less than one day

7

hr

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Jesse Siler

13. Birthplace

N.C.

14. Maiden Name

Cardie Ayers

15. Birthplace

?

16 (a) Informant Baltimore City Hospitals

(b) Address

Records

17 (a) Cremation

(Burial, cremation, or removal)

(b) Date thereof

11-1-73
(month) (day) (year)

(c) Cemetery or crematory

Baltimore City Hospitals
Location 4940 Eastern Ave., Baltimore, Md.

18 (a) Funeral director

(b) Address

NOV 2 - 1943 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1943 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1943 to 10-29 1943, and that I last saw him alive on 10-29 1943.

Immediate cause of death

Malnutrition

Due to Inability to digest food

Due to

Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Balto. City Hosp

Date signed 10-29

Duration
6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this form is important. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

443390
G 09732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G 09732

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

8 days

3 (a) FULL NAME

John J. RAVERS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

HARRISON

6 (c) If alive, give age

65 years

7. Birth date of deceased (mo., day, yr.)

8-31-77

8. AGE:

Years

Months

Days

- If less than one day

66

-

-

hr.

min.

9. Birthplace

GA

(Town, county, and state)

10. Usual Occupation

RETIRED

11. Industry or business

FATHER
MOTHER

12. Name

JACOB RAVERS

13. Birthplace

GA

14. Maiden Name

JOANNAH McDONALD

15. Birthplace

Scotland

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

11/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory?

Location

Savannah, GA

18 (a) Funeral director

26. W. Meier & Son

(b) Address

805 N. Talbot St.

19 (a)

Date of death

NOV 2 - 1943

Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

GA

(b) County

(c) City or town

SAVANNAH

(If outside city or town limits, write RURAL and give town)

(d) Street No.

201

E. 37

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

NOV 1

1943. at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1943. to Nov 1 1943. and that I last saw him alive on Nov 1 1943.

Immediate cause of death

Shock

Due to

nephrectomy

Due to

FOR Kidney tumor (right kidney)

Other Conditions

Anterioritis

(Include pregnancy within 3 months of death)

Date of operation

11/1/43

Major findings of operation:

Kidney tumor (right)

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. H. Williams

Address

Date signed 11/1/43

89733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09733

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2805 Sunset Drive

(c) Hospital or institution:

At Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)(d) Street No. 2805 Sunset Drive
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

William A Ruark

3 (b) If veteran, name war

No

3 (c) Social Security Account

No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Annie J. Ruark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 14, 1888

8. AGE:

Years

Months

Days

If less than one day

55018

hr.

min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

Automobile Painter

11. Industry or business

Lin. Hards. Co. - Ind.

FATHER

MOTHER

12. Name

Charles P. Ruark

13. Birthplace

Baltimore Md.

14. Maiden Name

Temperance Carwell

15. Birthplace

Baltimore Md.

16 (a) Informant

Mrs Annie J. Ruark

(b) Address

2805 Sunset Drive17 (a) Burial(b) Date thereof Nov. 5/43
(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Ch.

Location

4439 Behar Road

18 (a) Funeral director

Edward W. Conklin

(b) Address

924 E. Eager St.

NOV 2 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st. 1943 at 5:00 PM21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1943 to Nov 1 1943, and that I last saw him alive on Oct 31 1943.Immediate cause of death Cerebral Artery DurationMyocardia. Arterio SclerosisHypertension. Ins. Sclerosis

Due to

Due to

Other Conditions

Pulmonary Embolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Robert C. HatchAddress 2151 - Walnut St. Date signed 1/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09734
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *812 Regester Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *5 Wks*

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Sadye M Kelly Fell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Charles Fell*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1881

8. AGE: Years

62

Months

Days

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Clerk

11. Industry or business

*Hess. Shoe Store*FATHER
MOTHER12. Name *Peter Kelly*13. Birthplace *Ireland*14. Maiden Name *Mary O'Dea*15. Birthplace *Ireland*16 (a) Informant *Edmund Williams*(b) Address *236 N. Harrison Ave*17 (a) *Burial* (b) Date thereof *11-3-1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Cathedral*

Location

18 (a) Funeral director *Mary M Wiedefeld*(b) Address *501 E. 1223 St*19 (a) *2-1943* (b) *Huntington Williams, M.D.*
(Date of registration) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) *812 Regester Ave* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *302 E. 20th St*

(If rural give location)

(e) Citizen of foreign country

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH *October 30* 19 *43* at *6:30 M*21. I certify that death occurred on the date above stated; that I attended deceased from *7/12/* 19 *43* to *9/15/* 19 *43*and that I last saw him or her alive on *Oct. 29* 19 *43*Immediate cause of death *Cerebral Hemorrhage*

Duration

Due to *Hypertension and Arterial Sclerosis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature *J. S. Sheldon*Address *Medical Arts Building* Date signed *11/2/43**J. S. SHELDON EASTLAND*

Physician: please write the cause of death clearly and legibly.

G 09735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09735

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

Street address W. M. H.

(c) Hospital or institution:

Union Green Hosp 17(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County Baltimore(c) City or town Forest Hill

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? No

(Yes or No)

If yes, name country

3 (a) FULL NAME

Alice Wiley Scarff (Mrs) Philip Leroy Scarff.

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife Phillip Leroy Scarff6 (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) Aug 13 1892

8. AGE:

Years

Months

Days

If less than one day

512 1/219

hr.

min.

9. Birthplace

Ind.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name Thos. H. Wiley13. Birthplace Ind.

MOTHER

14. Maiden Name Elizabeth Wheeler15. Birthplace Lynchville Ind16 (a) Informant Husband Philip Leroy Scarff(b) Address Forest Hill, Ind.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Nov 6 1943

(month, day) (year)

(c) Cemetery or crematory

Grundy Chapel

Location

Fallston Heights, Ind.

18 (a) Funeral director

Master & Son

(b) Address

Lynchville Ind.

19 (a)

Date by registrar

Nov 13 1943

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21943, at 2:40 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1943 to Nov 2 1943, and that I last saw her alive on Nov 2 1943

Immediate cause of death

Pulmonary edemaDue to pneumoniaDue to Solar pneumoniaDue to Depressive stuporOther Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

John A. Washburn, Jr.

M. D.

Address Union Memorial Hosp Date signed 11-2-43

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09736

Registered No.

(over)

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *1132 Warner St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *41*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *Baltimore*

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1132 Warner St*

(If rural give location)

(e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Willie Mae Rookland Lee

3 (b) If veteran, name war _____

3 (c) Social Security Account No. _____

4. Sex

2

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Single married

6 (b) Name of husband or wife

Richard Henry Lee

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 6, 1922

8. AGE:

Years

Months

Days

If less than one day

*21**3**24**35*

hr.

min.

9. Birthplace

Spartanburg S.C.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER

12. Name

Willie Moody

13. Birthplace

Spartanburg S.C.

MOTHER

14. Maiden Name

Mary Fogg

15. Birthplace

Spartanburg S.C.

16 (a) Informant

Willie Rookland

(b) Address

*1132 Warner St*17 (a) *Burial*

(b) Date thereof

November 4, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mount Pleasant

Location

Baltimore, Md.

18 (a) Funeral director

Joseph B. Smith

(b) Address

409 N. Mount Street

19 (a)

Huntington Williams

(b) Address

1132 Warner St

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct. 31 1943, 3:29 P.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *July 19 1943* to *Sept 28 1943* and that I last saw him alive on *Sept 28 1943*

Immediate cause of death

*Pulmonary T. B.*Due to *Tubercle Bac.*

Due to

Other Conditions

(Include pregnancy within 9 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury

23. Signature

Ed Mansell Lawrence

Address

1032 W. Lenoir St

Date signed

11-2-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

NOV 2 - 1943

G 09737

BALTIMORE CITY HEALTH DEPARTMENT

G 09737

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 809 Caton Ave

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mary Martha Auer

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

John Auer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 15 - 1879

8. AGE:

Years

Months

Days

If less than one day

64

3

15

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Charles Schuchart

13. Birthplace

U.S.A.

14. Maiden Name

Josephine Falkstich

15. Birthplace

U.S.A.

MOTHER

16 (a) Informant

Miss Mary Auer

(b) Address

809 Caton Ave

17 (a) Burial

(b) Date thereof Nov. 3 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore

18 (a) Funeral director

George L. Schuchart

(b) Address

2101 Frederick Ave

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

609 Caton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

28. DATE OF DEATH

Oct. 30

1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1943, to 10-30 1943.

and that I last saw him alive on: 19

Immediate cause of death Coronary Occlusion

Duration

10-25-43

Due to Coronary Sclerosis

5 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

H. L. Williams

Address 1514 E. Fair Place

M. D.

Date signed 11-2-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every word should be legible. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V 2 - 1943

G 09738

BALTIMORE CITY HEALTH DEPARTMENT

G 09738

CERTIFICATE OF DEATH

Registered No.

46E

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4302 Old York Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 713 Bate Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Sarah E. Zech

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Joseph E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 16, 1887

8. AGE:

Years

Months

Days

If less than one day

56

9

15

hr.

min.

9. Birthplace

Harford Co Md

(Town, county, and state)

10. Usual Occupation

Home Wife

11. Industry or business

FATHER

12. Name

John P. Lwaayer

13. Birthplace

Baltimore Co Md

MOTHER

14. Maiden Name

Sarah Turner

15. Birthplace

Baltimore Co Md

16 (a) Informant

Joseph E. Zech

(b) Address

713 Bate Ave

17 (a) Burial

(b) Date thereof Nov 3, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Road

18 (a) Funeral director

John A. Moran

(b) Address

3000 E Baltimore Md

19

Nov 3, 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No 713 Bate Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1943, to Oct 31, 1943, and that I last saw her alive on Oct 31, 1943.

Immediate cause of death

Terminal Bronchopneumonia

Duration

3 days

Due to

Due to

Other Conditions Generalized abdominal Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Anthony J. Thomas

M. D.

Address 4600 York Rd

Date signed 11/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every year, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information written on this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Adams - 23rd St.
G 09739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09739

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

3012 Harty Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No.

3012 Harty Lane

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Yvonne Pernot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Evlyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1908

8. AGE: Years

Months

Days

If less than one day

35

hr.

min.

9. Birthplace

Springfield, Missouri

(City, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

?

13. Birthplace

same

14. Maiden Name

Lottie G. ?

15. Birthplace

Vancouver, Arkansas

16 (a) Informant

Clara Burton

(b) Address

3012 Harty Lane

17 (a) Burial

(b) Date thereof 1-3-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Catharine's

Location

18 (a) Funeral director

Adolphus H. H. H.

(b) Address

717 E. Pratt Ave

19 (a)

(b)

(Date rec'd by registrar)

NOV 3 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-1

1943 at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15-1943 to 11-1-1943, and that I last saw him alive on 11-25-1943.

Immediate cause of death

Hypertension Cordi-
sclerotic disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Maxwell Adams

Address

312 BL 3rd St

Date signed

11-1-43

G 09740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09740

Registered No.

83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane

(c) Hospital or institution:

Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 665 W. Fayette St (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No. - non

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1872

8. AGE: Years Months Days If less than one day
70 7 11 2 hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Robert Hurtt

13. Birthplace ~~Charlotte~~ ~~Hurtt~~ ~~Unknown~~

14. Maiden Name Charlotte Hurtt

15. Birthplace Unknown

16 (a) Informant Mrs. Hurtt

(b) Address 3104 Belmont Ave

17 (a) Burial (b) Date thereof 11/3/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Lawn Park
Location Frederick Road

18 (a) Funeral director Howard N. Blight Jr.

(b) Address 4914 Belair Road

19 (a) (b)

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1943, at 1:00 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1943, to Oct 31 1943, and that I last saw him alive on Oct 29 1943.

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. N. Pullermon

Address 7324 Reisterstown Rd Date signed 11/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

NOV 3 - 1943

09741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09741

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 2504 Halcyon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Carrie E. Baker

3 (b) If veteran, name was

3 (c) Social Security Account

No. NONE

4 Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife John A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1865

8. AGE: Years Months Days If less than one day

78 0 14 hr. min.

9. Birthplace Baltimore MD

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Frederick A. Baker

13. Birthplace Baltimore MD

14. Maiden Name Catherine Scott

15. Birthplace Baltimore MD

16 (a) Informant Frederick A. Baker

(b) Address 2504 Halcyon Ave

17 (a) Date of death 11/3/43

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory St. Mary's Cemetery

Location Baltimore MD

18 (a) Funeral director William J. Cook Inc

(b) Address 1219 St. Paul St

19 (a) Date signed by 11/3/43

(b) Signature Huntington Williams, M.D.

Address 3723 Howard St

Date signed 11/3/43

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 2504 Halcyon Ave

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1943 8:15 M

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Oct 15 1943 11/1 1943

and that I last saw him alive on 11/1 1943

Immediate cause of death Hypertensive

Cardio-vascular

Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. J. Cook

Address 3723 Howard St

Date signed 11/3/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09742

BALTIMORE CITY HEALTH DEPARTMENT

G 09742

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2007 E. Lombard St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1(e) Length of stay in Baltimore (yrs., mos., or days) 3 1/2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Balti

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 E. Lombard St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Samuel E. C. Walstrom

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-12-7024

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or

Married6 (b) Name of husband or wife Bertha Walstrom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1876

8. AGE: Years Months Days If less than one day

6784

hr.

min.

9. Birthplace Harford Co. Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Samuel S. Walstrom13. Birthplace Harford Co. Md.14. Maiden Name Mariet Caatler15. Birthplace Harford Co. Md.16 (a) Informant Bertha Walstrom(b) Address 2007 E. Lombard St17 (a) Burial (b) Date thereof 11/4/43

(Burial, cremation, or other)

(month) (day) (year)

(c) Cemetery or other place Leeds Methodist ChurchLocation Cecil Co. Md.18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul St.

19 (a) (b)

Registered

NOV 3 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1943 7:20 PM21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct 1 1943 to Nov 1 1943
and that I last saw him alive on Nov 1 1943

Immediate cause of death

Coronary ThrombosisDuration 1 yr

Due to

Due to Coronary ThrombosisDuration 1 Day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward J. CookAddress 2530 E. Belmore Date signed 11/4/43

Registrar

Huntington Williams, M.D.

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G 09743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 902 Wheeler Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Charles Edward Degele

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-01-0968

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, divorced

Divorced6 (b) Name of husband or wife Audrey Degele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11-1895

8. AGE: Years Months Days If less than one day

48 5 21 hr. min.9. Birthplace Balto. Md.

(City, county, and state)

10. Usual Occupation Printer11. Industry or business Morris Lesser Co12. Name Henry Degele13. Birthplace Md.14. Maiden Name Annie B. Callis15. Birthplace Va.16 (a) Informant Henry Degele(b) Address 902 Wheeler Ave17 (a) Burial (b) Date thereof 11/4/43

(Burial, cremation, or other disposal) (month) (day) (year)

(c) Cemetery or crematory Moreland ParkLocation Parkville Md18 (a) Funeral director William Croft Inc(b) Address 127 St. Paul St

19 (a) (b)

(Date rec'd by registrar)

Registrar

VS 160 NOV 3-1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 902 Wheeler Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2-1943 A.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from April 1 1943 to Nov 2 1943and that I last saw him alive on Nov 1943

Immediate cause of death

Acute nephritis - GraminDue to Rheumatoid heart disease& acute myocardial infarctionDue to mitral stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert J. SchuchatAddress 2302 Elm St Date signed 11/2/43

N. P.

SHUCHAT

Duration

5 days

?

?

?

?

?

?

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09744

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Monument and Rutland Ave.*

(c) Hospital or institution:

Simi Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *6 days*(e) Length of stay in Baltimore (yrs., mos., or days) *6 days*

3 (a) FULL NAME

Baby Boy Grosfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *October 28 1943*8. AGE: Years Months Days If less than one day
6 days hr. min.9. Birthplace *Baltimore Md.*

(Town, county, and state)

10. Usual Occupation

Newborn

11. Industry or business

12. Name *Michael Grosfeld*13. Birthplace *Russia*14. Maiden Name *Sara Fisher*15. Birthplace *Baltimore Md.*16 (a) Informant *Sara Grosfeld*(b) Address *3301 Norman Ave. Balto.*17 (a) *Burial* (b) Date thereof *11/3/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Bellevue Roadside*Location *Hamilton Ave*18 (a) Funeral director *St. Lawrence Bros*(b) Address *1124 - 26th North Ave*19 (a) *NOV 3 1943*

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balto.*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *3301 Norman Ave.*(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 2 1943 at 11:25 AM*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 28 1943* to *Nov. 2 1943* and that I last saw him alive on *11/1 1943*

Immediate cause of death

Mongolism.

Due to

Due to

Other Conditions *CARDIAC?*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Dr. J. H. Williams*Address *1039 N. Calver St.* Date signed *11/2/43*

Physician

PHYSICIAN

Underline the cause to which death should be charged statistically.

Registered No. _____

V8 151

09746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09746
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **3317 FAIT AVE**

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **26**

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County(c) City or town **BALTIMORE**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **3317 FAIT AVE**

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY OVERGONE

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) **NOV. 2, 1943**8. AGE: Years Months Days If less than one day
3 hr. **30** min.9. Birthplace **BALTIMORE MD**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **JOHN OVERGONE**13. Birthplace **BALTIMORE MD**14. Maiden Name **GRACE CLEMSEN**15. Birthplace **BALTIMORE MD**16 (a) Informant **JOHN OVERGONE**(b) Address **3317 FAIT AVE**17 (a) **BURIAL** (b) Date thereof **11/3/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **OAK LAWN**Location **COLFATE MD**18 (a) Funeral director **Widely Funeral Home**(b) Address **2408 Orleans St.****NOV 3 - 1943**
(Date rec'd by registrar) **Huntington Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Novemb. 2 1943** at **3:00** P. M.21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 2 1943** to **Nov. 2 1943** and that I last saw her alive on **Nov. 2 1943**.

Immediate cause of death

AsphyxiaDue to **Infiltration of asphyctic**
ligion into the lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

NONE

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

J. G. RosenblattAddress **3018 O'Donnell St.** Date signed **10/2/43**

Duration

3 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G 09747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09747
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2309 Ocala Avenue
(c) Hospital or institution:
Finley Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Woodlawn Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

Fannie Falconer Rodgers

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife William Rodgers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1865

8. AGE: Years 78 Months 2 Days 3
If less than one day
hr. min.

9. Birthplace Frederick, Md.

(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

12. Name William H. Falconer

13. Birthplace Wash., D. C.

14. Maiden Name Mary A. J. Boteler

15. Birthplace Wash., D. C.

16 (a) Informant Maurie F. Rodger

(b) Address 411 Woodlawn Road

17 (a) Burial (b) Date thereof 11/3/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery the cemetery Lorraine

Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) NOV 3 - 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1943, at 6:15 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Feb 1936 to 11/1 1943
and that I last saw her alive on 11/1 1943

Immediate cause of death.

Myocarditis -
Arterio-sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. H. Roddy

Address 1403 Park Ave.

Date signed 11/2/43

Duration

Subsult

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information written on this certificate is especially important. Physicians: please write the cause of death clearly and legibly.
correct age is especially important.

G 09748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09748

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3202 Bayonne Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3202 Bayonne Ave.

(If rural, give location)

(e) Citizen of foreign country?

NO

(Yes or No)

If yes, name country

3 (a) FULL NAME

Frederick Tober

3 (b) If veteran, name war

3 (c) Social Security Account

No. 219-07-4146

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Ottellie Tober

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st, 1872

8. AGE: Years Months Days If less than one day
71 5 0 hr. min.9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Chair Factory

12. Name John Tober

13. Birthplace Germany

14. Maiden Name Louise Leischner

15. Birthplace Germany

16 (a) Informant Mr. Robert Tober

(b) Address 3202 Bayonne Ave.

17 (a) Burial (b) Date thereof NOV. 4, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Moreland Park
Location Taylor Ave. Parkville, Md.

18 (a) Funeral director L. A. Funeral Home

(b) Address 7401 Belair Road

19 (a) NOV 3 - 1943

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st, 1943 11.22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1943. Nov 1 1943. and that I last saw him alive on Nov 1 1943.

Immediate cause of death

Coronary of Stomach

Duration

1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 3 1943

Major findings of operation

Coronary of Stomach

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

L. A. Tober and

Address 5106 Hampden Rd

Date signed 11-2-43

PLEASE WRITE IN PRINT, WITH CAPS, AND IN INK. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09749
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1117 Brewer St.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **17-2**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No **1117 Brewer St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ADDIE MERRITT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Jan 1, 1901**

8. AGE:

Years **42**Months **10**Days **-**

If less than one day

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name **Richard Clark**13. Birthplace **Va.**14. Maiden Name **?**15. Birthplace **?**16 (a) Informant **Mr. John R. Merritt**(b) Address **1210 Druid Hill Av.**17 (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **11-3-43**

(month) (day) (year)

(c) Cemetery or crematory

Location **Weldon, N. C.**18 (a) Funeral director **Mrs Frances A. Hemsley**(b) Address **578 W. Biddle St.**

NOV 3 - 1943
Registered by **Huntington Williams, M.D.**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **NOV. 1, '43** 19 **at 7A** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 2 1943** to **Nov. 1 1943**, and that I last saw him alive on **Nov. 1 1943**.

Immediate cause of death

Coronary of Arteries

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address **861**Date signed **Nov 3**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09750
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

604 Bruce St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

604 Bruce St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 16, 1894

8. AGE:

Years

Months

Days

If less than one day

69

6

15

hr.

min.

9. Birthplace

A. G. Co. Md.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Wm. Wallace

13. Birthplace

Md.

14. Maiden Name

D. A. H. ?

15. Birthplace

Md.

16 (a) Informant

(b) Address

Mrs. Edith Sney

17 (a)

Burial

(b) Date thereof

11.4.43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn Cem.

Location

Baltimore, Md.

18 (a) Funeral director

Mrs. D. A. H. Sney

(b) Address

571 W. ...

19 (a)

NOV 3 - 1943

(Date of registration)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 31

1943, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerosis

Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

at

M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature

Robert L. ...

M.D.

Date signed

Nov. 1 1943

G 09751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09751
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Linda Branch

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-16-43

8. AGE: Years Months Days If less than one day

7

15

hr.

min.

9. Birthplace Balto. Md.

(Town, county and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

George Saunders

13. Birthplace

Md.

14. Maiden Name

Bertha Woodruff

15. Birthplace

Md.

16 (a) Informant

Bertha Branch

(b) Address

1010 W. Lexington St.

17 (a) Burial

(b) Date thereof 11-3-43

(Burial, cremation, or reburial)

Mt. Auburn Cem.

(c) Cemetery or crematory

Location Baltimore Md.

18 (a) Funeral director

Frances A. Hensley

(b) Address

578 W. Biddle St.

19 (a)

(Date rec'd by registrar)

(b)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

255 Schreiner St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1943, at 5:20 A.M.

21. I certify that I took charge of the remains described above, held an
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to death on the day stated above, and death in my
opinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Trauma due to
3rd degree burns.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury October 31, 1943, at 4:50 P.M.

(b) Where did injury occur? 255 Schreiner St.

(c) Did injury occur at home, on farm, industrial place, in public
place? at home While at work? No

(d) Means of injury Conflagration at home

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed November 1, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09752

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 128 S. Wolfe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2(e) Length of stay in Baltimore (yrs., mos., or days) 60

3 (a) FULL NAME

John Wolf

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Kunigunde

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

June 1864

8. AGE:

Years

Months

Days

If less than one day

794

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Retired

12. Name

Michael Wolf

13. Birthplace

Germany

14. Maiden Name

Margaret

15. Birthplace

Germany

16 (a) Informant

Family

(b) Address

128 S. Wolfe St

17 (a)

burial

(b) Date thereof

11/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Belair Rd.

18 (a) Funeral director

W. H. E. Dippel

(b) Address

1000 E. E. Ave.

19

NOV 3 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No.

128 S. Wolfe St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 31 1943 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1943 to Oct 31 1943 and that I last saw him alive on 10/31/1943.

Immediate cause of death

myocardosis

Due to

arteriosclerosis

Due to

senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. E. Dippel

M. D.

Address

14 W. Edg Ave

Date signed

11/2/43

G 09753

Adole Toffry
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 480

G 09753

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2137 N. Smallwood

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days) 15-4

(e) Length of stay in Baltimore (yrs., mo., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2137 N. Smallwood

(If rural give location)

(e) Citizen of foreign country? Naturalized (Yes or No)

If yes, name country.

3 (a) FULL NAME

Adole Toffry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

widowed

6 (b) Name of husband or wife

Waldemar

3 offrs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 12 1881

8. AGE:

Years

Months

Days

If less than one day

67

8

20

hr.

min.

9. Birthplace

Riga Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Don't know

13. Birthplace

Russia

14. Maiden Name

Don't know

15. Birthplace

Russia

16 (a) Informant

Mrs. Helen Jones

(b) Address 2137 N. Smallwood St.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

Nov. 4, 1943

(c) Cemetery or crematory

Mt. Olivet

Location

Balti. Md.

18 (a) Funeral director

Edgar S. Little

(b) Address

3700 Edmonson Ave

19 (a)

(Date rec'd)

NOV 8 - 1943

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1943 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1942 to Nov. 1 1943, and that I last saw him alive on Nov. 1 1943

Immediate cause of death

Carcinoma of uterus with metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Paul Brown

Address

1630 North

Date signed

11/2/43

Duration

1941

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09754
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name-war

(c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or Business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

NOV 3 1943

VB 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1942, to 19

and that I last saw him alive on NOV 2 1943

Immediate cause of death

Cerebral hemorrhage and paralysis.

Due to

Arteriosclerosis and hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2224 Garrison

Date signed

M. D.

Nov 3/43

G 09755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09755
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1817 Hough St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Ignatius Seabard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 15/43

8. AGE: Years Months Days

If less than one day

19.

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Charles Seabard

13. Birthplace Baltimore

14. Maiden Name Veronica Pastanowicz

15. Birthplace Baltimore

16 (a) Informant Veronica Pastanowicz

(b) Address 1817 Hough St

17 (c) Burial, cremation, or removal

(b) Date thereof Nov. 3/43.

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Frank W. Gzazowski

(b) Address 1930 Eastern Ave

19 (a) NOV 3 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1817 Hough St

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1943, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Nov. 1 1943, to Nov. 3 1943.

and that I last saw him alive on Nov. 3 1943.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 2 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature Leo L. Kalucki

Address 126 S. Patterson Pl.

Date signed Nov. 3/43

M. D.

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Date signed Nov. 3/43

Physician

Signature

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

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Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR DENOTES

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09756

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09756
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 507 Mosher St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2

(e) Length of stay in Baltimore (yrs., mos., or days) unknown

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

Col

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years Months Days If less than one day
61 5 — — hr. min.

9. Birthplace Virginia
(town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden Name unknown

15. Birthplace

16 (a) Informant Little Bates

(b) Address 1009 W. Lafayette Ave

17 (a) Burial (b) Date thereof 11 4 43
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematorium W. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) NOV 3 1943 William A Jackson Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 Mosher St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1943 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1943 to Nov 1 1943, and that I last saw him alive on Oct 30 1943.

Immediate cause of death

Coronary vascular disease

Due to hypertension

Due to atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. William Fry

Address 6908 P. A. Ave Date signed 11/3/43

Duration

unknown

Sept 3/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09757
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Md. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 749 Wilmer Alley
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Broadley Perkins

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Negro

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife James Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 - 19148. AGE: Years Months Days If less than one day
29 5 17 hr. min.9. Birthplace Annapolis Md
(Town, county, and state)10. Usual Occupation House wife

11. Industry or business

12. Name Thomas & Bell13. Birthplace Va14. Maiden Name Sarah Taylor15. Birthplace N.Y.16 (a) Informant Sarah Bell(b) Address 749 Wilmer Court17 (a) Burial (b) Date thereof 11 3 43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt. Auburn CemLocation Baltimore Md18 (a) Funeral director William A. Jackson(b) Address 916 Lexington Ave19 (a) NOV 3 1943 (b) Huntington
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-1943 at 3:30 P.M.21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Thomas J. Wolcott M.D.
Date signed 10-31-43 Medical Examiner.

T.N G 09758
52185BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09758
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5014 Frederick Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mary Scheimant, Mary or Mary Scheminant

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Widow

6 (b) Name of husband or wife. Desurigard (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1-1858

8. AGE: Years 85 Months 6 Days 1 If less than one day
hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Edward Crone

13. Birthplace GERMANY

14. Maiden Name Dora Steinmauer

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Nov. 5/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18 (a) Funeral director Philip Sturges Sons

(b) Address 2024 Orleans St. Baltimore, Md.

19 NOV 3 - 1943
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1943 at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 7/1 1943 to 11/2 1943.
and that I last saw him alive on 11/2 1943.Immediate cause of death Acute
coronary failureDue to A-S C.V. disease
& hypertension

Due to

Other Conditions Aortic aneurysm
arteriosclerosis; atherosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. J. Surman M.D.

Address 13 C H Date signed 11/2

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09759

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09759

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 416 S. Oldham St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 416 S. Oldham St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Maggie Kane

3 (b) If veteran, name war

3 (c) Social Security Account

No. ---

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

divorced. Widow

6 (b) Name of husband or wife John T. Kane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1872

8. AGE: Years

71

Months

6

Days

18

If less than one day

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

none

11. Industry or business

FATHER

12. Name Wm. Hettchen

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Caroline Olsenbach

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Margaret GORB

(b) Address 416 S. Oldham St.

17 (a) Burial (b) Date thereof Nov. 3/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location Balto. Md.

18 (a) Funeral director Philip Henry Jones

(b) Address 2024 Orleans St.

NOV 3 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29/43 19 at 2:10 PM

21. I certify that death occurred on the date above stated that I attended deceased from 10-10 1943 to 10-29 1943. and that I last saw her alive on 10-28 1943

Immediate cause of death

My patient's Cardiac
Deceleration
Due to Coronary Thrombosis
Ch. Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. T. F. Newman M. D.

Address 7549 Eastern Ave. Date signed 10/11/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09760

Rachael Shein
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09760

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring & Belvedere Aves.

(c) Hospital or institution:

Holmes Home for Aged & Infirm(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 months(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street Belvedere & Green Spring Aves.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Rachael Shein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

female

5. Color or race

white6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife

Jacob Shein

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1867

8. AGE: Years

76

Months

Days

If less than one day

hr.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Russia

MOTHER

14. Maiden Name

Unknown

15. Birthplace

Russia

16 (a) Informant

Revindale Records

(b) Address

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

11-3-43

(month) (day) (year)

(c) Cemetery or crematory

United Hebrew Cemetery

Location

Washington Blvd.

18 (a) Funeral director

Jack Lewis Inc.

(b) Address

1739 E. Balto. St.

19 (a)

NOV 3 - 1943Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1943 at 12:10 PM21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1942 to Nov 2 1943, and that I last saw her alive on Nov. 2 1943.

Immediate cause of death

Ch. carb. vascular disease
Hypertension, Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edmund Lewis

Address

Revindale

Date signed

12/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVED FOR BINDING

09761

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09761

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County Baltimore

(c) City or town

Pachyderm Beach

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Middle River

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

CHARLES

E.

DADDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1889

8. AGE: Years 54 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual Occupation Insurance Agent

11. Industry or business

12. Name John W. Dadds

13. Birthplace Chestertown Md

14. Maiden Name Alice W. Culley

15. Birthplace Chestertown, Md

16 (a) Informant Charles W. Dadds

(b) Address 2822 Locust Ave.

17 (a) Burial (b) Date thereof Nov 5/43
(burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory London Park
Location Hydrick Road

18 (a) Funeral director Harry Lutz

(b) Address 203 N. Broadway

NOV 3 - 1943 (b) Huntington Williams, Md?

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1st 1943 at 5:10 PM

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. J. Wallenweber M.D.

Date signed 11-2-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09762
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Don Secours Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Vincent Innes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 NOV 3 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2/1943 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31/1943 to 11/2/1943 and that I last saw him alive on 11/1/1943

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09763

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

84

7

28

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

17 (a)

(Burial, cremation, or removal)

17 (b) Date thereof

(Month) (day) (year)

(c) Cemetery or cremation

Location

18 (a) Funeral director

(b) Address

19 (a) NOV 3 - 1943

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/2 1943 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941 to Nov 2 1943, and that I last saw her alive on Nov 2 1943.

Immediate cause of death

Coronary thrombosis

Due to Arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09764

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *St. Joseph's Hospital*
(c) Hospital or institution(d) Length of stay in hospital or inst. (yrs., mos., or days) *16 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *1626 Ellamont St.*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George L. O'Rourke

3 (b) If veteran, name war

3 (c) Social Security Account
No. *213-10-0339*

4. Sex

M

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Caroline O'Rourke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 14/1884

8. AGE:

Years

Months

Days

If less than one day

*59**9**18**17*

hr.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Slur Inspector

11. Industry or business

Balto Transit Co

FATHER

12. Name

Michael O'Rourke

13. Birthplace

Ireland

MOTHER

14. Maiden Name

Mary

15. Birthplace

Ireland

16 (a) Informant

Gordon L. O'Rourke

(b) Address

1626 Ellamont St

17 (a)

Burial

(b) Date thereof

Nov 5, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Goodlawn

Location

Goodlawn Md

18 (a) Funeral director

Harry H. Ammon

(b) Address

4224 Parkview Ave

19 (a)

NOV 3 - 1943

(Date rec'd by registrar)

(b) *Wilmington Delaware*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *11-1-1943* at *9:48 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *10/27* 1942, to *11-1-1943*, and that I last saw him alive on *11-1-1943*.

Immediate cause of death

Peritonitis -

Due to

Perforation of Sigmoid

Due to

Intussusception

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *10-31-42*Major findings of operations: *Perforation of Sigmoid - fecal matter in peritoneal cavity.*of autopsy: *same.*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Walter E. Chiodi*Address *St. Joseph's Hospital* signed *11-1-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09765

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Maryland General Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *2 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind* (b) County(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *1607 Linden Ave*
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

*WINIFRED**HAYES*

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. *239-05-2807*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 26* 19*43*, at *10* M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

*Meningitis, acute suppurative**pneumococci*Due to *sinusitis, ethmoid**acute suppurative*

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?

(d) Means of injury

23. Signature *H. Z. Wollmuth* M.D.Date signed *10-27-43*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Beatrice Johnson*6 (c) If alive, give age *25* years7. Birth date of deceased (mo., day, yr.) *Nov 26, 1900*

8. AGE:

Years

Months

Days

If less than one day

*43**14**14**hr.**min.*

9. Birthplace

Ashville, N. C.

(Town, county, and state)

10. Usual Occupation

Boiler Roomman

11. Industry or business

Shipyard

12. Name

Chas. Hayes

13. Birthplace

North Carolina

14. Maiden Name

Julia Finney

15. Birthplace

North Carolina

16 (a) Informant

Mrs. B. Hayes

16 (b) Address

*518 7th Street*17 (a) *Burial*(b) Date thereof *11/6/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Ashville, N. C.

18 (a) Funeral director

Thos. J. Emery

Address

1000 Hillside Rd.

NOV 3 - 1943

(Date rec'd by registrar)

W. Williams

G 09766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09766

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2815 Ailsa ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2815- Ailsa ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George W. Greenholt

3 (b) If veteran, name war

3 (c) Social Security Account

No. 218-08-1089

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married6 (b) Name of husband or wife May Hulman6 (c) If alive, give age 77 years7. Birth date of deceased (mo., day, yr.) June 24-18618. AGE: Years 82 Months 4 Days 8 If less than one day
hr. min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER

12. Name James Greenholt13. Birthplace md.

MOTHER

14. Maiden Name Annie Bixler15. Birthplace md16 (a) Informant Melvin Greenholt(b) Address 2815- Ailsa ave17 (a) Burial (b) Date thereof Nov 4/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory ManchesterLocation Manchester md18 (a) Funeral director Edw. Chilton(b) Address 2 Hampstead md

19 (a) (b)

(Date rec'd by registrar) Registrar

NOV 3 - 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2, 1943 at 5:00 P. M21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22, 1943 to Nov 2, 1943 and that I last saw him alive on Nov 2, 1943.

Immediate cause of death

Virus Pneumonia

Duration

12 days

Due to

Due to

Other Conditions Postic regurgita 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. H. SingwaldAddress 1613 E. North Ave M. D.Date signed 11-3-43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09767
Registered No. 2

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County Howard(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)(d) Street No. Montgomery Road
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

GEORGE ROSNER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

m

5. Color or race

w

6 (a) Single, married, widowed, or
divorced

Married

6 (b) Name of husband or wife

Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-10-74

8. AGE:

Years

Months

Days

If less than one day

69

4

21

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

Butcher

FATHER
MOTHER

12. Name

Joseph Rosner

13. Birthplace

Germany

14. Maiden Name

Elij. Wital

15. Birthplace

Germany

16 (a) Informant

Margaret Rosner

(b) Address

Elkridge, Md.

17 (a)

Burial

(b) Date thereof

11-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

18 (a) Funeral director

C. Vernon Lemmon

(b) Address

4611 Pk. 169/3

NOV 3 - 1943 (b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1943, at 9:30 AM

21. I certify that I took charge of the remains described above, held an

inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work?

(d) Means of injury

23. Signature W. J. Wallenmeyer M.D.Date signed 11-2-43 Asst. Medical Examiner.

G 09768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09768
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2514 Frederick Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Frederick Schulteis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Loretta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 23, 1909

8. AGE:

Years

Months

Days

If less than one day

34

-

10

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Iron Worker

11. Industry or business

H. Orgdarks

12. Name

George Schulteis

13. Birthplace

New York, N.Y.

14. Maiden Name

Mary Hill

15. Birthplace

Md.

16 (a) Informant

Jacob F. Schulteis

(b) Address

26 N. Morley St.

17 (a)

Burial

(b) Date thereof

Nov. 6, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

New Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

William Cook Inc.

(b) Address

1217 St. ...

19

NOV 3 - 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-3-

1943

at

1:50 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Hemorrhage due to incised

wound of throat, involving

Dance Carotid artery - sublethal

Injury vein

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

11-3-43 at

1:30 A.M.

(b) Where did injury occur

at front of 24 N. Balt. St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Sharp instrument

Signature Howard J. Macleod

M.D.

Date signed 11-3-43

Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09769

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo. 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Harford

(c) City or town Lapidum, Havre de Grace P. O.
(If outside city or town limits, write RURAL and give town)

(d) Street No. -
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

CHARLES WAYNE KIMMEL

3 (b) If veteran, name war

World's War

3 (c) Social Security Account

No. -

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva A. Smith

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 16, 1888

8. AGE: Years Months Days If less than one day

55

5

18

17

hr.

min.

9. Birthplace Cumberland County, Pa.

(Town, county, and state)

10. Usual Occupation Storekeeper - 6 yrs. ago

11. Industry or business

12. Name John Kimmel

13. Birthplace Cumberland County, Pa.

14. Maiden Name Minnie May Burns

15. Birthplace Cumberland County, Pa.

16 (a) Informant Records, U. S. Marine Hosp.

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Nov. 5, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Elone Cem.
Location Near Harrisburg, Pa.

18 (a) Funeral director H. S. Bailey

(b) Address Baltimore, Md.

19 (a) Nov. 3, 1943 Wilmington, Delaware

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Nov. 3, 1943 at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1943 to Nov. 3, 1943, and that I last saw him alive on Nov. 3, 1943.

Immediate cause of death Right hemiplegia due to metastases

Duration
Approx.
1 mo.

Due to Carcinoma of left lung with metastases to brain Approx. 6 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. S. Bailey

Address Baltimore, Md.

Date signed 11/3/43

Va-13746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

69770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09770
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood + Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 55 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Baltimore
(d) Street No.: 2540 McCullough St.
(e) Citizen of foreign country? (If rural give location) (Yes or No)

3 (a) FULL NAME: Glenn M. Thompson
3 (b) If veteran, name war: ? 3 (c) Social Security Account No.: ?

4. Sex: Male 5. Color or race: Colored 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Georgia Thompson 6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1880
8. AGE: Years: 63 Months: Days: If less than one day: hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business:
12. Name: William Thompson
13. Birthplace: Richmond Co. Va.
14. Maiden Name: Julia
15. Birthplace: Richmond Co. Va.
16 (a) Informant: Wife (b) Address: 2540 McCullough St.
17 (a) (Burial, cremation, or removal) (b) Date thereof: 11-3-43 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn Cemetery
Location: Baltimore, Md
18 (a) Funeral director: Cecilio A. Stoddie
(b) Address: 2401 McCallister St
NOV 3 - 1943 (Huntington Williams, Registrar)

20. DATE OF DEATH: 10-31-43 19 5:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 - 1943 to Oct 31, 1943, and that I last saw him alive on 10-31-43
Immediate cause of death: Coronary
Due to: Chronic Coronary
Due to: Hypertension & atherosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operations:
of autopsy: same
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury: (Specify type of place)
23. Signature: Roy M. Jones M. D.
Address: Date signed: 11-4-43

09771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09771
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 521 N. Decker Ave.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

BABY GIRL CONRAD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 - 42

8. AGE: Years Months Days If less than one day
26 hr. min.9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Michael Conrad

13. Birthplace Balto. Md.

14. Maiden Name Mary Suchs

15. Birthplace Balto. Md.

16 (a) Informant St. Joseph's Hosp

(b) Address Caroline St.

17 (a) Burial (b) Date thereof Nov. 5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. Pan.

Location North Ave. & Gay St.

18 (a) Funeral director John A. McEllen

(b) Address 2524 Jefferson St.

(b) Huntington Williams, M.D.

Registral

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1943, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1943, to 11/3 1943, and that I last saw him alive on 11/3 1943.

Immediate cause of death

Bilateral Broncho-pneumonia

Due to.

Due to.

Other Conditions Generalized peritonitis

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operations.

of autopsy: as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. B. Ballena

M. D.

Address St. Joseph's Date signed

Not.

11/5/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 3 - 1943

6 09772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09772
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Halethorpe

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2011 Northeast

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) FULL NAME

Carolyn Lee Mc Corkle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5 Color or race

6 (a) Single, married, widowed, or divorced

FEMALE

WHITE

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1943

8. AGE: Years Months Days If less than one day
4 hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name Henry Mc Corkle

13. Birthplace North Carolina

14. Maiden Name Cora Lee Coulter

15. Birthplace North Carolina

16 (a) Informant Hospital Records

(b) Address Johns Hopkins Hospital

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL NOV 3 1943

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 3 - 1943 Huntington Williams, M.D.
Signed and sealed by Registrar

VB 159

0481

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1943 at 2:00 PM

21. I certify that death occurred on the date above stated, that I attended

and deceased from Oct. 9 1943 to Oct. 13 1943

and that I last saw her alive on Oct. 13 1943

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Johns Hopkins Hospital Date signed NOV 3 - 1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

109773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09773
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **16-3**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME **Baby girl Hooper**3 (b) If veteran, name war
3 (c) Social Security Account No.4. Sex **Female** 5. Color or race **Black** 6 (a) Single, married, widowed, or divorced **Single**6 (b) Name of husband or wife
6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) **10-20-43**8. AGE: Years Months Days If less than one day
3 hr min.9. Birthplace **Md**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name **LONIA HOOPER**13. Birthplace **VA**14. Maiden Name **IRENE COCHRAN**15. Birthplace **VA**16 (a) Informant **Records**
(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location **JOHN HOPKINS MEDICAL SCHOOL NOV 3 1943**18 (a) Funeral director **Commissioner of Health**

(b) Address

NOV 3-1943 (b) **Huntington Williams**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **BALTIMORE**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **611 BRUCE COURT**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 20 1943** at **8:00 P**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 20 1943** to **Oct 20 1943**, and that I last saw him alive on **Oct 20 1943**.

Immediate cause of death

prematurity

Due to

? **Thyroidal abortion**
(mother fell down 4-1 slip)
Other Conditions **night before delivery**

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Helen B. Davis**Address **Johns Hopkins Hosp.** Date signed **10/21/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09774

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5517 Gwynn Oak Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5517 Gwynn Oak Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Euriale Prevost, Jr.

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife M. Caroline Prevost

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) October 4, 1868

8. AGE: Years Months Days If less than one day
85 - 28 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Accountant

11. Industry or business

12. Name Euriale Prevost

13. Birthplace Baltimore, Md.

14. Maiden Name Valerie Bizouard

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. M. Caroline Prevost

(b) Address 5517 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof Nov. 4, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director William L. Lamm

(b) Address 4510 Liberty Heights Ave.

NOV 3 - 1943 William L. Lamm

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 19 43, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 42, to Oct. 19 43, and that I last saw him alive on Oct. 30 19 43.

Immediate cause of death Asphyxiation

Duration

Due to Laryngeal carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert B. Laroque

Address The Walbert Apts.

Date signed 11/2/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

19775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09775
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 211 N. Durham St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 211 N. Durham St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mary Robinson

3 (b) If veteran, name war

(c) Social Security Account
No.

4. Sex

Female Colored

5. Color or race

6 (a) Single, married, widowed, or divorced

Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 19008. AGE: Years 43 Months 3 Days 11 hr. 14 min.9. Birthplace Northumberland Co. Va.
(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

12. Name Edica Crockett13. Birthplace Va14. Maiden Name Emily Veni15. Birthplace Va.16 (a) Informant Fannie Morris(b) Address 1304 E. Lexington St.17 (a) Burial (b) Date thereof 11/5/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory mt Calvary
Location18 (a) Funeral director Elroy Wilson(b) Address 1000 Brandt AveNOV 3 - 1943 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11. 2. 1943 at 6:30 AM21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1943 to Nov 2 1943, and that I last saw him alive on Nov 2 1943.

Immediate cause of death

Acute Myocarditis

Duration

10

Due to

Lobar Pneumonia

4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

Signature Dr. L. BerryAddress 1420 E. Chase Date signed 11-2-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1976 443813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09776
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **416 N. Caroline St**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

George Blake

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

12-3-87

8. AGE: Years

55

Months

56

Days

10

If less than one day

29 hr. min.

9. Birthplace

Red Top, S. C.
(Town, county, and state)

10. Usual Occupation

Radio Technician

11. Industry or business

12. Name

James Blake

13. Birthplace

va

14. Maiden Name

Maria

15. Birthplace

?

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

11/7/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arboretum Mem. Pk.

Location

18 (a) Funeral director

Eloy Wilson

(b) Address

1000 Brentley Ave

NOV 3 - 1943

(b) **Huntington Williams, MD**

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 2 1943 at 6:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 1 1943 to Nov. 2 1943** and that I last saw him alive on **Nov. 2 1943**

Immediate cause of death

Cardiac

failure

Due to

Paroxysmal ventricular tachycardia

Due to

! Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

T B Schwartz

Address

Date signed

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09777
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2 (a) FULL NAME

Baby David Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name John Berger

13. Birthplace Baltimore, Md.

14. Maiden Name Eris Patsley

15. Birthplace Balto, Md.

16 (a) Informant John Berger,

(b) Address Green Haven Pasadena, Pa.

17 (a) Burial (b) Date thereof Nov 4 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Haven Memo. Cem.

Location Green Bay, Md.

18 (a) Funeral director Thomas W. Livingston

(b) Address Green Bay, Md.

19 NOV 3 - 1943

20 (a) Registered by

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County Anne Arundel

(c) City or town Green Haven Pasadena, Pa.
(If outside city or town limits, write RURAL, and give town)

(d) Street No. East Shore Road + 7th Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1943, at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1943 to Nov. 2 1943, and that I last saw him alive on Nov. 2 1943.

Immediate cause of death Lobal Pneumonia

Due to

Due to

Other Conditions Diarrhea of Infancy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William H. Livingston

Address St. Joseph's Hosp Date signed 11-6-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09778
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 - N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital 26-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hours

(e) Length of stay in Baltimore (yrs., mos., or days) 14 hours

3 (a) FULL NAME

KAREN SALMI JANSEN

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex
F

5. Color or race
W

6 (a) Single, married, widowed, or divorced.
INFANT

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1943

8. AGE: Years Months Days If less than one day
14 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Aimo John Hamsen

13. Birthplace Conneaut, Ohio

14. Maiden Name Elsie Marie Salmi

15. Birthplace Baltimore, Maryland

16 (a) Informant Aimo J. Jansen

(b) Address 819 S. Rappola St.

17 (a) Burial (b) Date thereof 11/4/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cemetery
Location Baltimore County

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 NOV 4 - 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

6148 - Rappola St.

(e) Citizen of foreign country?

(If rural give location)

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1943 at 12:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1943 to 10/30 1943, and that I last saw him alive on 10/30 1943.

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

Primaries separation of placenta
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. B. Ballina

Address

St. Joseph's Hosp

M. D.

Date signed

10/30/43

G 09779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09779

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1625 Mosher St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 1625 Mosher St
(If rural give location)(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

Louise Franklin Barnett

3 (b) If veteran, name was

none

3 (c) Social Security Account

No. none

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or

divorced Widow

6 (b) Name of husband or wife

Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1889

8. AGE: Years Months Days If less than one day

531119

hr.

min.

9. Birthplace

Balto, Md.

(Town, county, and state)

10. Usual Occupation

Domestic

11. Industry or business

FATHER
MOTHER12. Name Henry Roberts13. Birthplace Balto. Md14. Maiden Name Hester Roberts15. Birthplace Balto. Md.16 (a) Informant Jennie Franklin (10)(b) Address 1625 Mosher St17 (a) Burial

(Burial, cremation, or removal)

(b) Date 11/5/43

(month) (day) (year)

(c) Cemetery or crematory Mt. CalvaryLocation A.A. County, Md.18 (a) Funeral director Charles G. Cooper(b) Address 512 N. Carrollton Ave.19 (a) NOV 4 1943

(b)

Registrar

VB 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1943, at 3 20 A M21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Chronic myocardial
degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? _____ While at work? _____

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed Nov. 1 1943

G 09780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09780

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Madison - Bureau*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *4333* *Hayford Rd.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife *Bessie C. Rauer*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

63 10 hr. min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *Amos Baughman*13. Birthplace *Pa.*

14. Maiden Name

15. Birthplace

16 (a) Informant *Bessie C. Baughman*(b) Address *4333 Hayford Rd.*17 (a) *Burial* (b) Date thereof *11-6-43*

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory *Quaker Friends*Location *Pa.*18 (a) Funeral director *Leonard J. Ruck*(b) Address *5305 Hayford Rd.*19 *NOV 4 1943*

VS 118

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 3 1943* at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *2/19/1943* to *11/3/1943*and that I last saw him alive on *Nov. 2 1943*Immediate cause of death *Acute Dehydration*
Myocardial Infarction

Due to

Due to *Myocarditis*Other Conditions *Arteriosclerosis*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide *no*(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Thomas F. White*Address *622 E 22nd St*Date signed *11/3/43*Duration *14 min.*
*20 min.**Dr. J. H. White*
Dr. J. H. White

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09781

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *2632 Maryland Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *12*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2632 Maryland Ave.* (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male White

married

6 (b) Name of husband or wife *Bessie G.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Aug. 30 - 1871*

8. AGE: Years Months Days If less than one day
72 2 2 hr. min.

9. Birthplace *Delaware*
(Town, county, and state)

10. Usual Occupation *retired Penna. R.R.*

11. Industry or business

12. Name *Israel Williams*

13. Birthplace *Penna.*

14. Maiden Name *Anne Shallcross*

15. Birthplace *Delaware*

16 (a) Informant *Mrs. Bessie G. Williams*

(b) Address *2632 Maryland Ave*

17 (a) *Burial* (b) Date of removal *11-2-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Baltimore*
Location *Baltimore, Maryland*

18 (a) Funeral director *Leonard J. Ruck*

(b) Address *5409 Franklin St. Baltimore*

19 (a) *NOV 1 1943*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 2, 1943, 11:0 P. M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *June, 1936*, to *Nov. 2, 1943*, and that I last saw him alive on *Oct. 30, 1943*.

Immediate cause of death

Coronary occlusion

Due to *Arteriosclerosis*

Due to *Diabetes*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

1 yr.

15 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature *George E. Cross*

Address *38 W 25th St* Date signed *11-3-43* M. D.

09782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09782

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1521 Leslie St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

William S. Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex

M

5. Color or race

Col

6 (a) Single, married, widowed, or divorced.

M.

6 (b) Name of husband or wife

Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 26, 1877

8. AGE: Years Months Days

66 63

2 6

hr. min.

9. Birthplace

Lenn

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

12. Name

Roy Duncan

13. Birthplace

Lenn

14. Maiden Name

unobtainable

15. Birthplace

16 (a) Informant

Irene, Duncan

(b) Address

1521 Leslie St

17 (a)

Burial

(b) Date thereof 11/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

Mt Auburn

18 (a) Funeral director

Geo. S. Kelson

(b) Address

1303 Presolman St

NOV 4 - 1943

(b) Hunting for Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balt

(If outside city or town limit, write RURAL and give town)

(d) Street No.

1521 Leslie St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 2

1943 at 7:20 AM

21. I certify that death occurred on the date above stated that I attended deceased from 8/11 1942 to 11/2 1943 and that I last saw him alive on 11/2 1943.

Immediate cause of death

Hypertensive Type Heart Disease

Due to

Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

Means of injury

23. Signature

Wm. H. Hughes

Address

601 N. Calhoun St

Date signed 11/5/43

09783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

09783

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof 11-4-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 NOV 4 - 1943

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL, and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 1 1943, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1943 to NOV 1 1943 and that I last saw him alive on NOV 1 1943

Immediate cause of death

Cerebral hemorrhage
Due to hypertensive disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 536 W. Leland St

Date signed 11/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Duration

3 hours

1 yr.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09784

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1008 N Vincent

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

3 (a) FULL NAME

John Clark

3 (b) If veteran, name war

no

3 (c) Social Security Account

No.

4. Sex

Male Negro

5. Color or race

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Annie Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1868

8. AGE:

Years

Months

Days

If less than one day

75

hr.

min.

9. Birthplace

N.E.

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Unknown

13. Birthplace

N.E.

14. Maiden Name

Unknown

15. Birthplace

N.E.

16 (a) Informant

Lillian Green

(b) Address

1008 N Vincent

17 (a) Burial

(b) Date thereof

11/4/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt Auburn

Location

Mt Auburn

18 (a) Funeral director

George S. Kaban

(b) Address

1303 P. Chestnut St

(a) 1 - 1943

(b)

Huntington Williams, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street

1008 N Vincent

(If rural give location)

(e) Citizen of foreign country?

no

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1

1943

at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1943 to Nov 1, 1943.

and that I last saw him alive on Nov 1, 1943.

Immediate cause of death

Myocarditis

Due to

Duration

?

Due to

Other Conditions

Hypertension

?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Lillian H. Watts

Address 675 L. G. Ave

Date signed 11/3/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09785
442015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09785
51B
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W. VA (b) County

(c) City or town CLARKSBURG
(If outside city or town limits, write RURAL and give town)

Street No. 312 S. Chesnut st.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ARTHUR A. Cather

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

MARY

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 9-12-64

8. AGE: Years 79 Months 1 Days 21 If less than one day
hr. min.

9. Birthplace

W. VA
(Town, county, and state)

10. Usual Occupation Keeper of Cemetery

11. Industry or business

12. Name John Cather

13. Birthplace W. VA

14. Maiden Name Elizabeth ERVIN

15. Birthplace VA

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Nov 4
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Clarksburg, W. Va

18 (a) Funeral director Kelley's Funeral Home

(b) Address 204 E. Baltimore

(c) Huntington Williams, M.D.

Nov 4 - 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1943, at 10:50 P

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1943 to Nov 3 1943, and that I last saw him alive on Nov 3 1943

Immediate cause of death

Pulmonary embolus

Duration

35 days

Due to Postoperative 35 days

following perineal

prostatectomy for

carcinoma of prostate

Other Conditions essential hypertension

PHYSICIAN

Underline the cause to which death should be charged statistically.

(Include pregnancy within 2 months of death)

Date of operation October 1, 1943

Major findings of operation: Carcinoma

of prostate

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature James A. Singler

Address Johns Hopkins Hosp. Date signed 11/4/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09786
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address FAYETTE + CALHOUN ST.

(c) Hospital or institution:

FRANKLIN SQUARE Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 dn.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

LORE OUTTEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Doris

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

Mar. 28, 1880

8. AGE: Years

63

Months

7

Days

3

If less than one day

hr.

min.

9. Birthplace

Pocomoke City, Worcester Co., Md.

(Town, county, and state)

10. Usual Occupation

FARMER & School-bus driver

11. Industry or business

FATHER
MOTHER

12. Name

William Outten

13. Birthplace

Maryland

14. Maiden Name

Mary Frances Watson

15. Birthplace

Maryland

16 (a) Informant

Lora Outten, Jr.

(b) Address

Basin, Md.

17 (a)

Burial

(b) Date thereof

Nov. 5, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Halla Hill Cem.

Location

Pocomoke city, Rural

18 (a) Funeral director

Margaret H. Watson

(b) Address

Pocomoke City, Md.

19 (a)

Nov 4 - 1943

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Worcester

(c) City or town

Rural Pocomoke

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/1

1943 at 1:00 P.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from 10/9 1943 to 11/1 1943.

and that I last saw him alive on 11/1 1943.

Immediate cause of death

Coronary Occlusion?

Due to

Due to

Other Conditions

Transmural Pericarditis

Rheumatic - L. Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation 10/17 & 10/26/43

Major findings of operations

Basilar Pontate Myelopathy

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature Levin E. Gardner

Address 133 Station St. Date signed 11/2/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09787
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 2531 E Oliver St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife: Amelia Doersch

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) 12-26-1861

8. AGE: Years 52 Months — Days 5 If less than one day hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name: John Doersch

13. Birthplace: Germany

14. Maiden Name: Not Known

15. Birthplace: Germany

16 (a) Informant: Mrs Oscar Ford

(b) Address: 2531 E Oliver St

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: Nov 5/43 (month) (day) (year)

(c) Cemetery or crematory: First Gen Ex Cem Location: O'Donnell St Balto

18 (a) Funeral director: Wm Lusk Funeral Home

(b) Address: 2008 Orleans St

19 (a) NOV 4 1943 (Date rec'd by registrar) Registrar: Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State: MD (b) County: Balto

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No: 2531 E Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 1943 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct: 29 1943 to Nov: 1 1943, and that I last saw him alive on Nov: 1 1943.

Immediate cause of death:

Due to: Coronary Thrombosis

Due to: Atherosclerosis

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature: Michael J. Doersch

Address: 2530 E. Baltimore St Date signed: 11/3/43

Duration

1 hour

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09788

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2918 Clifton Pk. Ter.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **8-1**

(e) Length of stay in Baltimore (yrs., mos., or days) **60 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County
(c) City or town **Baltimore Md.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2918 Clifton Pk. Ter**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Anna E.W. Fuller

3 (b) If veteran, name war

None

3 (c) Social Security Account No. **None**

4. Sex
F.

5. Color or race
W.

6 (a) Single, married, widowed, or divorced.
Widow

6 (b) Name of husband or wife **Albert Fuller**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Dec. 6, 1871**

8. AGE: Years Months Days If less than one day
71 10 25 hr. min.

9. Birthplace **Baltimore Md.**
(Town, county, and state)
None

10. Usual Occupation

11. Industry or business

12. Name **Henry Miller**

13. Birthplace **Germany**

14. Maiden Name **Elisebeth Wise**

15. Birthplace **U.S.A.**

16 (a) Informant **Luther Fuller**

(b) Address **2918 Clifton Pk. Ter.**

17 (a) **Burial** (b) Date thereof **Nov. 4 43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Oak Lawn**
Location **Eastern Ave.**

18 (a) Funeral director **L. Heemann and Son**

(b) Address **32 S. Broadway**

19 (a) **NOV 4 - 1943**

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 1, 1943** at **9 A.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 3, 1943** to **Nov 1, 1943**, and that I last saw her alive on **Oct 31 1943**.

Immediate cause of death

Coronary thrombosis

Due to

Cardio-vascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **August Fuller, M.D.**

Address **2739 Eastern Ave** Date signed **11/2/43**

Duration

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

09789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09789

Registered No.

131a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 653 W. Fayette St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

No. 215-09-0153

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Mary J. Brown

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr)

Jan 1, 1889

8. AGE:

Years

Months

Days

If less than one day

54

9

2

hr.

min.

9. Birthplace

New York N.Y.

(Town, county, and state)

10. Usual Occupation

Wood Cooper

11. Industry or business

The Cooper Co.

12. Name

Edward Brown

13. Birthplace

Brooklyn N.Y.

14. Maiden Name

Unknown

15. Birthplace

Brooklyn N.Y.

16 (a) Informant

Mrs. Mary J. Brown

(b) Address

653 W. Fayette St

17 (a)

Burial

(b) Date thereof

11/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Olivet

Location

2930 Fred Rd.

18 (a) Funeral director

John J. Brown & Son

(b) Address

991 Hollins St

19 (a)

Huntington Williams

NOV 4 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/3

19

4:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions: Generalized Arteriosclerosis
Chronic Myocardial Degeneration
(Include pregnancy within 6 months of death)22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Wessels M.D.

Date signed 11-3-43 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09750

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

At less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

NOV 4 1943

VS 124

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/2

1943 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1943, to Nov. 2, 1943, and that I last saw him alive on Nov. 2 1943.

Immediate cause of death

myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

517 Acote St.

Date signed 11/4/43

M. D.

11/4/43

09791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09791

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

D.O.A. West Baltimore Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 2440 Edmondson Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1885

8. AGE: Years 58 Months 0 Days 29
If less than one day hr. min.9. Birthplace Balt., Md.
(town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

12. Name Charles Schermann

13. Birthplace Balt., Md.

14. Maiden Name Emily K. Joyce

15. Birthplace Balt., Md.

16 (a) Informant M.R. J. Earl Schermann

(b) Address 2440 Edmondson Ave.

17 (a) Burial (b) Date thereof 11/5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Fickner

(b) Address North La Penna, Ave.

NOV 4 - 1943 (Data rec'd by registrar) Huntington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1943 at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Aortic Aneurysm
(Ruptured)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McWhally, M.D.

Date signed 11/2/43 Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **94a** **09792**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **2931 W. North Ave.**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) **15-6**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2931 W. North Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

EDITH SCHOFIELD

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. **none**

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife **James**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 26, 1871**

8. AGE: Years Months Days If less than one day
71 11 6 hr. min.

9. Birthplace **Oldham, England**
(Town, county, and state)

10. Usual Occupation **Housewife**

11. Industry or business

FATHER 12. Name **Samuel Hilton**

13. Birthplace **England**

MOTHER 14. Maiden Name **Elizabeth Hilton**

15. Birthplace **England**

16 (a) Informant **Mr. James Schofield**

(b) Address **2931 W. North Ave.**

17 (a) **Burial** (b) Date thereof **11/5/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Western Cem.**
Location **Baltimore, Md.**

18 (a) Funeral director **WM. J. TICKNER & SONS**

(b) Address **Balto., Md.**

NOV 4 - 1943 *starting for Williams, M.D.*
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 2, 1943, at 2:30 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 12 1943, not 2 1943** and that I last saw him alive on **Oct 30 1943**.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation **about**

Major findings of operation:

of autopsy: **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence **✓** at **M**

(c) Where did injury occur? **✓** (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? **✓** While at work? **✓**
(Specify type of place)

(e) Means of injury

23. Signature **Dr. J. H. Williams**

Address **1219 E. ...** Date signed **11/3/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09793		BALTIMORE CITY HEALTH DEPARTMENT		G 09793	
T.N.		81899		CERTIFICATE OF DEATH 937	
1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:			
(a) Baltimore City, Maryland		(a) State <u>Maryland</u> (b) County			
(b) Street address <u>4940 Eastern Ave</u>		(c) City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)			
(c) Hospital or institution: <u>Baltimore City Hospitals</u>		(d) Street No. <u>236 N. Pearl St</u> (If rural give location)			
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>5 months</u>		(e) Citizen of foreign country? (Yes or No) If yes, name country			
(e) Length of stay in Baltimore (yrs., mos., or days) <u>14 yrs</u>					
3 (a) FULL NAME <u>Harry Foster</u>					
3 (b) If veteran, name war			3 (c) Social Security Account No.		
4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6 (a) Single, married, widowed, or divorced. <u>Married</u>			
6 (b) Name of husband or wife <u>Mollie</u>					
6 (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) <u>? ? ?-53?</u>					
8. AGE: Years <u>53</u>	Months <u>?</u>	Days <u>?</u>	If less than one day <u>18</u> hr. <u>9</u> min.		
9. Birthplace <u>IOWA</u> (Town, county, and state)					
10. Usual Occupation <u>None</u>					
11. Industry or business					
12. Name <u>Frank Foster</u>					
13. Birthplace <u>?</u>					
14. Maiden Name <u>?</u>					
15. Birthplace <u>?</u>					
16 (a) Informant <u>Baltimore City Hospitals</u>					
(b) Address <u>4940 Eastern Ave</u> (Records)					
17 (a) <u>Burial</u> (b) Date thereof <u>Nov 5 1943</u> (Burial, cremation, or removal) (month) (day) (year)					
(c) Cemetery or crematory <u>Int Calvary</u> Location <u>and Co md</u>					
18 (a) Funeral director <u>James A. Stays</u>					
(b) Address <u>142 W. 11th St</u>					
19 (a) <u>NOV 4 1943</u> (b) <u>Huntington</u>					
MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>11/2</u> 19 <u>43</u> at <u>5:35 A</u>					
21. I certify that death occurred on the date above stated; that I attended deceased from <u>7/1</u> 19 <u>43</u> to <u>11/2</u> 19 <u>43</u> , and that I last saw him alive on <u>11/2</u> 19 <u>43</u> .					
Immediate cause of death <u>acute cardiac failure</u>					
Due to <u>Hypertensive C.V. disease</u>					
Due to					
Other Conditions					
(Include pregnancy within 3 months of death)					
Date of operation					
Major findings of operation: <u>enlarged heart; card. hypertrophy; atherosclerosis; aortic aneurysm; coronary artery disease</u>					
22. If death was due to external causes, fill in the following:					
(a) Accident, suicide, or homicide					
(b) Date of occurrence at <u>M</u>					
(c) Where did injury occur? (City or town) (County) (State)					
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?					
(Specify type of place)					
(e) Means of injury					
23. Signature <u>E. L. Sargman</u>					
Address <u>BCH</u> Date signed <u>11/3</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09794
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Agnes Hospital 280

(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Maryland* (b) County *Balto*

(c) City or town *Villa Nova Pikeville*

(d) Street No. *Campfield Road*

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME

Edgar Traurn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 1st 1942*

8. AGE: Years Months Days If less than one day

1 6 1 hr. min.

9. Birthplace *Pikeville Maryland*

10. Usual Occupation

11. Industry or business

12. Name *Edgar T. Traurn*

13. Birthplace *Balto. Md.*

14. Maiden Name *Daisy Fox*

15. Birthplace *Ba.*

16 (a) Informant *Edward Keys*

(b) Address *Campfield Rd. Villa Nova Md*

17 (a) *Buried* (b) Date thereof *11/4/43*

(c) Cemetery or crematory *St. Agnes Chapel*

Location *Pikeville, Maryland*

18 (a) Funeral director *Frank H. Howard*

(b) Address *Pikeville, Maryland*

19 (a) (b) *Huntington Williams, M.D.*

(Date rec'd by registrar) *NOV 4 - 1943*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 2 1943* at *8:25 AM*

21. I certify that death occurred on the date above stated; that I attended deceased from *10/31 1943* to *11/2 1943*, and that I last saw him alive on *11/2 1943*.

Immediate cause of death

Tubercin

Due to *2nd tumor*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide *accident*

(b) Date of occurrence *12/21/43* at *11 PM*

(c) Where did injury occur? *Pikeville* (City or town) *Md* (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *home* While at work?

(e) Means of injury *injured by copper*

23. Signature *J.P. Dwyer M.D.*

Address *St. Agnes Hosp* Date signed *11/2/43*

Duration

2 days

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09795

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09795

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 10 - 18928. AGE: Years Months Days If less than one day
51 2 23 hr. min.9. Birthplace York Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name P. J. Kuntz13. Birthplace York Pa.14. Maiden Name Mary J.15. Birthplace York Pa.16 (a) Informant Max B. Anstein(b) Address York Pa.17 (a) Burial (b) Date thereof Nov. 6 - 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Prophet Hill CemLocation York, Pennsylvania18 (a) Funeral director Burger Funeral Home(b) Address 321 Hells Road19 (a) NOV 4 - 1943 (b) Huntington Williams, M.D.
(Date of registration) (Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia County(b) City or town Tom's Brook
(If outside city or town limits, write RURAL and give town)

(c) Street No.

(d) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1943, at 7:55 M21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury November 3, 1943 M.(b) Where did injury occur? Central Police Station(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No(d) Means of injury Stabbed himself with knife23. Signature Robert E. Fulton M.D.Date signed Nov. 4, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09796

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Date received

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended and deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

NOV 4 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		G. 09797	
1. PLACE OF DEATH:				2. USUAL RESIDENCE OF DECEASED:	
(a) Baltimore City, Maryland				(a) State <u>Maryland</u> (b) County	
(b) Street address <u>4940 Eastern Ave.</u>				(c) <u>14-2</u> or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give town)	
(c) Hospital or institution: <u>BALTIMORE CITY HOSPITALS</u>				(d) Street No. <u>518 Wilson Street</u> (If rural give location)	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <u>3 yrs., 3 mos., 1 day</u>				(e) Citizen of foreign country? (Yes or No) If yes, name country	
(e) Length of stay in Baltimore (yrs., mos., or days) <u>13 yrs.</u>					
3 (a) FULL NAME <u>Eddie Hasty</u>				MEDICAL CERTIFICATION	
3 (b) If veteran, name war		3 (c) Social Security Account No.		20. DATE OF DEATH <u>11-2</u> 19 <u>40</u> , at <u>8:00 AM</u>	
4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6 (a) Single, married, widowed, or divorced <u>Married</u>		21. I certify that death occurred on the date above stated; that I attended deceased from <u>7-31</u> 19 <u>40</u> to <u>11-2</u> 19 <u>40</u> , and that I last saw him alive on <u>11-2</u> 19 <u>40</u> .	
6 (b) Name of husband or wife <u>Martha Hasty</u>				Immediate cause of death <u>Pulmonary infarct</u>	
6 (c) If alive, give age years				Duration <u>20 min</u>	
7. Birth date of deceased (mo., day, yr.) <u>1-11-1900</u>				Due to <u>Pulmonary infarct</u>	
8. AGE: Years <u>40</u>	Months <u>9</u>	Days <u>21</u>	If less than one day hr. min.	Due to <u>Potts disease of spine</u>	
9. Birthplace <u>South Carolina</u> (Town, county, and state)				Other Conditions	
10. Usual Occupation <u>Laborer</u>				(Include pregnancy within 3 months of death)	
11. Industry or business				Date of operation	
12. Name <u>Berry (D)</u>				Major findings of operations	
13. Birthplace <u>North Carolina</u>				of autopsy: <u>See above</u>	
14. Maiden Name <u>Charlotte Hasty</u>				22. If death was due to external causes, fill in the following:	
15. Birthplace <u>South Carolina</u>				(a) Accident, suicide, or homicide	
16 (a) Informant <u>BALTIMORE CITY HOSPITALS</u>				(b) Date of occurrence at <u>M</u>	
(b) Address <u>(RECORDS)</u>				(c) Where did injury occur? (City or town) (County) (State)	
17 (a) <u>Burial</u> (b) Date thereof <u>Nov. 6 1940</u> (Burial, cremation, or removal) (month) (day) (year)				(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?	
(c) Cemetery or crematory <u>Debuter Mem. Bk.</u>				(e) Means of injury	
Location <u>Baltimore, Md.</u>				23. Signature <u>J. and M. H.</u>	
18 (a) Funeral director <u>Mrs. George H. Holland</u>				Address <u>B. C. H.</u> Date signed <u>11/3/40</u>	
(b) Address <u>1631 District Hill Ave.</u>					
NOV 4 - 1940 (Date rec'd by registrar) <u>Huntington Williams, M.D.</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09798
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *11 days*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County

(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2017 Penn Ave*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Ira Edward Strong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 7, 1905*

8. AGE: Years Months Days If less than one day

37 4 24 hr. min.

9. Birthplace *Atlanta, Ga.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *William Strong*

13. Birthplace *Atlanta, Ga.*

14. Maiden Name *Fannie Williams*

15. Birthplace *Atlanta, Ga.*

16 (a) Informant *Archie Strong*

(b) Address *3303 Bator Ave.*

17 (a) *Burial* (b) Date thereof *Nov. 4, 1943*

(Burial, cremation, or removal) (month, day, year)

(c) Cemetery or crematory *Providence Hospital*

Location *Baltimore, Md.*

18 (a) Funeral director *Mrs. George H. Hollen*

(b) Address *1631 United Hill Ave*

(c) Date received by registrar *Nov 4 - 1943*

(d) *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 1 1943* at *12:45* p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 22 1943* to *Nov. 1 1943*, and that I last saw him alive on *Nov. 1 1943*.

Immediate cause of death

Myocardial Infarction
Coronary Disease

Due to

Due to

Other Conditions *Malignant Hypertension*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *J. B. Buziel*

Address *Providence Hospital* Date signed *11/2/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09799
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address
- (c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md** (b) County
- (c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
- (d) Street No. **2315 E Chase**
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Florence Moseetti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female White

5. Color or race

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-20-20

8. AGE:

Years

Months

Days

If less than one day

23 20 9**5****4**

hr.

min.

9. Birthplace

Md
(Town, county, and state)

10. Usual Occupation

H.W.

11. Industry or business

12. Name

John Bentz

13. Birthplace

Md

14. Maiden Name

Sophie Laber

15. Birthplace

Md

16 (a) Informant

Records

16 (b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

BURIAL

(b) Date thereof

11/6/43
(month) (day) (year)

(c) Cemetery or crematory

OAKLAWN

Location

EASTERN AVE.

18 (a) Funeral director

CLARENCE P. HOFFMANN

18 (b) Address

1639 BROADWAY

18 (c) Date of death

NOV 4 - 1943**Huntington Williams, M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov-2** 1943, at **11:24 P**21. I certify that death occurred on the date above stated; that I attended deceased from **Nov 2 1943**, to **Nov 2 1943**, and that I last saw her alive on **Nov 2 1943**.

Immediate cause of death

Cerebral hemorrhageDue to **Malignant Hypertension**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Paul O. ChatfieldAddress **Johns Hopkins Hosp**Date signed **11/3/43**

Duration

2 hrs.**6 yrs.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the causes of death clearly and legibly.

09800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09800

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
106 S. Conklin Street
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Conklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOSEPH FUSZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 24, 1907

8. AGE: Years Months Days If less than one day
36 8 8 7 hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

Shipping clerk

11. Industry or business

12. Name Peter Fuss

13. Birthplace Hungary

14. Maiden Name Mary C. Panhatek

15. Birthplace Hungary

16 (a) Informant Mary C. Fuss

(b) Address 106 S. Conkling St.

17 (a) Burial (b) Date thereof 11/5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

NOV 4 - 1943 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

4 P.

20. DATE OF DEATH November 1, 1943, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Cirrhosis of liver, atrophic.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. X. Wallenmeyer M.D.

Date signed November 2, 1943

09801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09801
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Md. General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 3125 Cliftmont Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Emanuel

E.

Jansen (Jensen)

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

married

6 (b) Name of husband or wife Margaret A. Edwards

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1892

8. AGE: Years Months Days If less than one day

50

10

4

hr.

min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Oil treater

11. Industry or business St. Oil Co.

12. Name Frederick W. Jensen

13. Birthplace Baltimore Md.

14. Maiden Name Ellen King

15. Birthplace Baltimore Md.

16 (a) Informant Margaret A. Jensen

(b) Address 3125 Cliftmont Ave.

17 (a) Burial (b) Date thereof 11/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

NOV 4 - 1943 (Huntington Williams, M.D.)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1943 at 10 AM

21. I certify that I took charge of the remains described above, held an
autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

heart

Rupture of

Due to Coronary occlusion and
infarction of heart

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Robert L. Graham M.D.

Medical Examiner.

Date signed Nov. 1 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

109802 Good Rely

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09802

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto Gen. Hosp. 214
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County
(c) City or town Baltimore
(d) Street No. 708 Carroll St.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country.

3 (a), FULL NAME

LeRoy Bensinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 1 1943

8. AGE: Years 3 Months 3 Days If less than one day hr. min.

9. Birthplace

BALTO MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name JAMES MC GHE SNEY
13. Birthplace IV D.
14. Maiden Name NORMA BENSINGER
15. Birthplace BALTO MD

16 (a) Informant MRS MARGT BINSINGER
(b) Address 708 CARROLL ST.

17 (a) BURIAL (b) Date thereof NOV 4 - 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOUNDON PARK
Location BALTO. MD.

18 (a) Funeral director Bernard C. Harbo
(b) Address 121 E West St

NOV 4 - 1943 (c) Date rec'd by registrar
(b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1943, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1943, to 11-4 1943, and that I last saw him alive on 11-4 1943.

Immediate cause of death

Premature

Duration 2 days

Due to (7 months)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles A. McDonald
Address 1213 Light St Date signed 11-4-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09803
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline + Stuart St

(c) Hospital or institution:

St Joseph's Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balts(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)(d) Street No. 1132 Riverside Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Blaise Peddicord

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife

Bartholomew Peddicord6 (c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years

42

Months

Days

If less than one day

hr.

min.

9. Birthplace

Annapolis Md
(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business

FATHER

12. Name George W. Evans13. Birthplace A A Co.

MOTHER

14. Maiden Name Elizabeth E. Figgis15. Birthplace A A Co.16 (a) Informant B. F. Peddicord(b) Address 1132 Riverside Ave17 (a) Burial
(Burial, cremation, or removal)(b) Date thereof Nov 6 - 43
(month) (day) (year)

(c) Cemetery or crematory

Cedar Bluff Cem

Location

Annapolis Md

18 (a) Funeral director

E. J. Lamoreaux(b) Address 1003 W. Baltimore St

NOV 4 - 1943

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3- 1943, at 10:20 PM21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1943 to 11-3 1943, and that I last saw him alive on 11-3 1943.Immediate cause of death Coronary OcclusionDue to Myocardial Cardiac Vasculature disease

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

Pneumonia of left lung
Emphysema - Fibroid uterus
Chronic bronchitis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harlan E. Crook

M. D.

Address St Joseph's Hospital Date signed 11-3-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09804
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 642 E. Fort ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Balto., Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 E. Fort ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Benjamin C. Freburger
3 (b) If veteran, name war no
3 (c) Social Security Account No. none

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Melva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1901

8. AGE: Years 42 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

12. Name Robert E. L. Freburger

13. Birthplace Balto., Md.

14. Maiden Name Anna E. McNamee

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Loretta McAnthony

(b) Address 642 E. Fort ave.

17 (a) Burial (b) Date thereof 11-6-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto., Md.

18 (a) Funeral director Fleming & Fleming

(b) Address 1426 Light St.

NOV 4 - 1943 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1943 at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1942, to Nov. 3 1943 and that I last saw him alive on 11-3 1943

Immediate cause of death Carcinoma of Liver

Due to
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-8-42

Major findings of operation: Carcinoma of Liver

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)

(e) Means of injury

23. Signature A. S. Collopy M. D.
Address 707 E. Fort Ave. Date signed 11-3-43

Duration 1 yr. +

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9805

AB-84053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09805

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4854 Pinlico Road

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

George Musgrove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1872

8. AGE: Years Months Days If less than one day

71

3 4

22 0

hr

min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name Josh Musgrove

13. Birthplace Md.

14. Maiden Name Hannah ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address Records

17 (a) (b) Date thereof 11/5/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Frederick 408.

18 (a) Funeral director

(b) Address

19 (a) 1 - 1943

(Date received by registrar)

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 1 1943, 12:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1943, to 11-1 1943, and that I last saw him alive on 11-1 1943.

Immediate cause of death

Pneumonia

Due to Fracture femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-1-43

Major findings of operations: Cast applied

of autopsy:

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide Patient injured

(b) Date of occurrence To give history 11/28/43

(c) Where did injury occur? 4854 Pinlico Rd

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No

(e) Means of injury Dropped and fell

23. Signature Donald B. H. H.

Address Baltimore City Hosp Date signed 11-2-43

Duration

24

1 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. H. H. Hollenhorst, by Thomas J. Madden, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09806

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1400 - N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Colesbury Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY BOY COOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
12 hr. min.

9. Birthplace St. Joseph Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name William Joseph Cook

13. Birthplace Balto Md

14. Maiden Name Josephine Harmon

15. Birthplace Balto Md

16 (a) Informant Mrs. Cook

(b) Address 625 Colesbury Ave

17 (a) Burial (b) Date thereof 11-4-1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Mary M. Winfield

(b) Address 301 E 22nd St

19 NOV 4 - 1943 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1943 11:43 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1943 to 11/3 1943, and that I last saw him alive on 11/3 1943.

Immediate cause of death

Pneumonia

Duration

Due to

Due to

Other Conditions

Primaturity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. B. Ballou

M. D.

Address St. Joseph's Hosp. Date signed

11/3/43

09807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09807
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Belmont & Green Sts.*

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *10 days*(e) Length of stay in Baltimore (yrs., mos., or days) *3 months*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD*

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. *306 S. Belmont St.*

(If rural give location)

(e) Citizen of foreign country? *no*

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Linda Lee Farley

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or

divorced.

single

6 (b) Name of husband or wife

Charles W. Farley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 9, 1943

8. AGE:

Years

Months

Days

If less than one day

*0**3**25*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

FATHER
MOTHER

12. Name

Charles Willey

13. Birthplace

Unknown

14. Maiden Name

Linda E. Farley

15. Birthplace

Baltimore, Md.

16 (a) Informant

Linda E. Farley

(b) Address

306 S. Belmont St.

17 (a)

Burial

(b) Date thereof

Nov 5 - 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Park

Location

City of Baltimore

18 (a) Funeral director

Robert C. M. Walton

(b) Address

1000 N. Charles St.

19 (a)

*Nov 4 - 1943**Dr. William M. P.*

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-3-43

19

at *7:00* *P.*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *10-25-43* 19 to *11-3-43*and that I last saw him alive on *11-3-43* 19

Immediate cause of death

congenital syphilis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Raymond S. Farley*Address *University Ave*Date signed *11-5-43*

Duration

*acute**toxic*

PHYSICIAN

Underline the

cause to which

death should be

charged statisti-

cally.

9838

HEALTH DEPARTMENT—CITY OF BALTIMORE

G C9808

CERTIFICATE OF DEATH

✓ 161a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington St., 12-6 Ward)

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 1 yrs. 1 mo. 1 da. How long in U. S. If of foreign birth? 1 yrs. 1 mo. 1 da.

2. FULL NAME

Wayne BaileyIf U. S. Veteran
specify WAR _____(a) Residence: No. 3417 Roland AveSt. 12-6

Ward.

(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. Color or Race <u>W</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
--------------------	------------------------------	--

6a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day, year)

Nov. 2, 1943

7. AGE	Years	Months	Days	If LESS than 1 day _____ hrs. or _____ min.
			<u>1</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country)Baltimore Md.

MOTHER

13. NAME

Paul Bailey14. BIRTHPLACE (city or town)
(State or country)Taneytown Md.

15. MAIDEN NAME

Viola Frey16. BIRTHPLACE (city or town)
(State or country)Leesburg, Va.

17. INFORMANT

Viola Bailey

(Address)

3417 Roland Ave

18. BURIAL, CREMATION, OR REMOVAL

Place UNIVERSITY MEDICAL SCHOOL NOV 4 1943

19. UNDERTAKER

(Address)

Commissioner of HealthNOV 4 - 1943Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year)

Nov. 3, 1943

22. I HEREBY CERTIFY, That I attended deceased from

Nov 2nd 1943 to Nov 3rd 1943I last saw him alive on Nov 2nd 1943 Death is saidto have occurred on the date stated above, at 1:45 PM

The principal cause of death and related causes of importance were as follows:

Obstruction of Lung.Date of onset
Nov. 2

Other contributory causes of importance:

Was an operation performed? _____ Date of _____

For what disease or injury?

Name of operation _____

What test confirmed diagnosis? _____

Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____

(Address) _____

J. H. M. M.D.
7101 Harford Road.

M. D.

10486

09809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09809

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St.

(c) Hospital or institution:

Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

Annie Major

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

91

hr.

min.

9. Birthplace Eastern Shore Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name

Serving

13. Birthplace

14. Maiden Name

Rose Martin

15. Birthplace

16 (a) Informant Little Sisters of the Poor(b) Address 1200 Valley St. Balto Md17 (a) Burial(b) Date thereof Nov. 5, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore

18 (a) Funeral director

Rita W. W. W.

(b) Address

914 Greenmount Ave

NOV 4 - 1943

(Date rec'd by registrar)

Hastington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1943 at 5 p m M21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Nov 3 1943, and that I last saw her alive on Nov 2 1943.

Immediate cause of death

Edema Lungs

Due to

Central Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. Gull HallAddress 1631 E North Ave

Date signed

M. D.

11/4/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09810

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1130 Barclay St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 + 1

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1130 Barclay St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John E. Curtin

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-00-4033

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Elizabeth McLaughlin

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

83

hr.

min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual Occupation Elec. Sub. Sta. Operator

11. Industry or business

FATHER

12. Name

James M. Curtin

13. Birthplace

Washington, D. C.

MOTHER

14. Maiden Name

Alaide Simons

15. Birthplace

Washington, D. C.

16 (a) Informant

Mrs. John E. Curtin

(b) Address

1130 Barclay St

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Nov. 6, 1943

(month) (day) (year)

(c) Cemetery or crematory

Cathedral

Location

Baltimore

18 (a) Funeral director

Rita Wiedefeld

(b) Address

914 Greenmount Ave

NOV 4 - 1943

VB 100

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 2 1943 7:35 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 12 1943 to Nov 7 1943,

and that I last saw him alive on Nov 1 1943

Immediate cause of death

Coronary Thrombosis

Due to

arteriosclerosis

Due to

generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of death

23. Signature

William R. Craft

Address

10 E Dade St

Date signed

11/4/43

09811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09811
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County(c) City or town Tampa

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3215 Swallow St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Tampa Fla

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Nov 6th 43
(month) (day) (year)

(c) Cemetery or crematory

Location Union of Italians
Tampa 4 Loyola

18 (a) Funeral director

(b) Address

NOV 4 - 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1943 at 11:00 PM21. I certify that death occurred on the date above stated; that I attended deceased from 11:3 1943, to 11:3 1943, and that I last saw him alive on 11:3 1943.Immediate cause of death Massive retroperitoneal + retroperitoneal hemorrhage

Duration

24 hrs.Due to Traumatic rupture of abdominal aorta

24 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Massive Hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident(b) Date of occurrence November 2, 1943 5 P. M.(c) Where did injury occur? Quinn School, Md.
A. A. Co. (City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? Public place While at work? no
(Specify type of place)(e) Means of injury Football scrimmage23: Signature William A. BullAddress University Hospital Date signed 11-4-43Approved: Robert Lee Graham M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09812
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd Street

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Belair - Annapolis
(If outside city or town limits, write RURAL and give town)(d) Street No. Belair, Md.
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Josephine L. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or
divorced.

Married

6 (b) Name of husband or wife Edward W. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/95

8. AGE: Years Months Days If less than one day

48

8

109

hr.

min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Charles E. Litzinger

13. Birthplace Maryland

14. Maiden Name Sarah E. Brown

15. Birthplace W. Va.

16 (a) Informant Edward W. Thomas

(b) Address 123 S. Main Street, Belair, Md.

17 (a) Burial (b) Date thereof 11/5/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bakers Cemetery

Location Abingdon, Md.

18 (a) Funeral director H. K. McComas & Son

(b) Address Abingdon, Md.

NOV 4 - 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1943, at 12:00 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct. 29 1943, to Nov. 1 1943,
and that I last saw her alive on Nov. 1 1943.

Immediate cause of death

Cardiac failure

Duration
4 hrs.

Due to 'Acute Pancreatitis'

Due to 'Acute Pancreatitis'

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 20, 1943

Major findings of operations: Adipose
& dilated common bile duct.
of autopsy: Acute Pancreatitis

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature William L. Thomas

Address New York, N.Y. Date signed 11/1/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 09813

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 616 Jasper St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Jasper St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Annie Downing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1/1882

8. AGE: Years 51 Months 5 Days 29 hr. min.

9. Birthplace Richmond Co., Va.
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name ? ? Downing
13. Birthplace Richmond, W. Va.
14. Maiden Name Dorcas Venev
15. Birthplace Richmond Co., Va.

16 (a) Informant Harry Venev
(b) Address 1341 Pennsylvania Ave

17 (a) Burial, cremation, or removal Serial
(b) Date thereof Nov. 5/1943
(c) Cemetery or crematory Family Cemetery
Location Richmond Co., Va.

18 (a) Funeral director Mrs. George A. Halland
(b) Address 1601 Druid Hill Ave

19 (a) Date of death NOV 4 1943
(b) Registered by J. H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/43 19 7th M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1/43, 11/1/43, and that I last saw him alive on 11/1/43

Immediate cause of death
Due to
Cerebral thrombosis
gum abscesses
pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature H. C. S. M.D.
Address 307 N. Moh. Ave Date 11/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09814

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City *Maryland + Baltimore*
 (b) Street address *State Hospital*
 (c) Hospital or institution: *Lincoln Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *1 wk.*
 (e) Length of stay in Baltimore (yrs., mos., or days) *life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *1629 E. Federal St.*
 (If rural give location)
 (e) Citizen of foreign country? *NO* (Yes or No)
 If yes, name country

3 (a) FULL NAME

HARRY CLAUD HOERSTER

3 (b) If veteran, name war
*NO*3 (c) Social Security Account
No. *NONE*

4. Sex

male

5. Color or race

*white*6 (a) Single, married, widowed, or divorced. *married*6 (b) Name of husband or wife *Ida F. Kling*6 (c) If alive, give age *71* years7. Birth date of deceased (mo., day, yr.) *Oct. 22, 1871*

8. AGE:

Years

72

Months

0

Days

12

If less than one day

hr.

min.

9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual Occupation

Retired Letter Carrier

11. Industry or business

*Post Office Dept.*FATHER
MOTHER12. Name *Frederick Hoerster*13. Birthplace *Germany*14. Maiden Name *Margaret Strahler*15. Birthplace *Germany*16 (a) Informant *Mrs. Ida F. Hoerster (wife)*(b) Address *1629 E. Federal St.*17 (a) *Burial* (b) Date thereof *Nov. 3, 1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Baltimore Cem.*Location *Baltimore Md.*18 (a) Funeral director *HENRY SANDER & SONS, INC.*(b) Address *North Ave. & Broadway,**NOV 5 - 1943*

VS 254

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov - 4* 19*43* at *M*21. I certify that death occurred on the date above stated; that I attended deceased from *10/26/1942* to *11/4/1943*, and that I last saw him alive on *11/4/1943*

Immediate cause of death

Coronary Occlusion

Duration

Due to

*Myocardial infarction
arterio sclerosis & pressure*

Due to

Other Conditions

*Prostatic Hypertrophy
Pericarditis*

(Include pregnancy within 3 months of death)

Date of operation *10/29/43*

Major findings of operation:

Arteriosclerosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address *Lincoln Hospital* signed *11/9/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09815

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *604 S. Newkirk St*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *26*

(e) Length of stay in Baltimore (yrs., mos., or days) *25 yrs.*

3 (a) FULL NAME

Anna Mary Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5 Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Harvey*

6 (c) If alive, give age *76 years*

7. Birth date of deceased (mo., day, yr.)

Feb. 11, 1877

8. AGE: Years Months Days

66 *8* *22* hr. min.

9. Birthplace *Fredrick Co. Md.*

(Town, county, and state)

10. Usual Occupation *Housework*

11. Industry or business *At Home*

12. Name *Nicholas Perkins*

13. Birthplace *Fredrick Co. Md.*

14. Maiden Name *Anna Mary Baley*

15. Birthplace *Fredrick Co. Md.*

16 (a) Informant *Mrs. Ruth Thomas*

(b) Address *635 S. Newkirk St*

17 (a) *Burial* (b) Date thereof *Nov. 5, 43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Oaktown*

Location *Baltimore Md*

18 (a) Funeral director *Wm. Cook & Son*

(b) Address *1217 St Paul St*

19 (a) (b) *Huntington Williams*

(Date rec'd by registrar)

Nov 5 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County

(c) City or town *Balto.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *604 S. Newkirk St.*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/3 1943 *2:00 PM*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *10/25 1943* to *10/2 1943*

and that I last saw him alive on *10/25 1943*

Immediate cause of death

CAUSE OF

LT. Bronch.

Due to

Due to

Other Conditions *METASTASIS*

TO LUNG BONES LUNGS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *No* While at work?

(Specify type of place)

(e) Means of injury *Green Bay*

23. Signature *L. B. Eastman*

Date signed *11/3/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09816
55E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 E. Lafayette Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT H. SEYMOUR

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1867

8. AGE: Years 76 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Trappe Md.
(Town, county, and state) retired

10. Usual Occupation Section Foreman

11. Industry or business M + P H R

12. Name George H. Seymour

13. Birthplace Maryland

14. Maiden Name Irene Callaway

15. Birthplace Maryland

16 (a) Informant Robert H. Seymour

(b) Address Home De Grasse Md

17 (a) buried (b) Date thereof Nov 8, 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Spring Hill Cem

Location Easton Md.

18 (a) Funeral director Wm. Cook & Co

(b) Address 1217 St Paul St

19 (a) NOV 5 - 1943

(b) Date of registration

VB 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1943, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1943, to Nov. 4, 1943, and that I last saw him alive on Nov. 4, 1943.

Immediate cause of death

GENERALIZED PERITONITIS

Due to PERFORATION OF LARGE BOWEL

Due to GENERALIZED LYMPHO-SARCOMA

Other Conditions GENERAL ARTERIO-SCLEROSIS

(Include pregnancy within 3 months of death)
Date of operation NOV. 1, 1943

Major findings of operation: LYMPHO-SARCOMA

of autopsy: GENERALIZED PERITONITIS

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jmg Robert L. [Signature]

Address SINAI HOSP. Date signed 11/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PEACABLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

920 G 09817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. 21st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(d) Street No. 18 W. 21st St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Margaret Ellen Dallmus
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Philip C. Jr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 4, 1882
8. AGE: Years 61 Months 6 Days 9 hr. min.
9. Birthplace Marysville Pa.
10. Usual Occupation Housewife
11. Industry or business

12. Name James W. Kacher
13. Birthplace Marysville Pa.
14. Maiden Name Mary Gentry
15. Birthplace Marysville Pa.
16 (a) Informant Philip C. Dallmus
(b) Address 18 W. 21st St.

17 (a) Burial (b) Date thereof Nov. 6, 1943
(c) Cemetery or crematory Parkwood
Location Baltimore Md
18 (a) Funeral director Wm. Cook & Co.
(b) Address 1212 St Paul St.
19 (a) NOV 5 - 1943

MEDICAL CERTIFICATION
20. DATE OF DEATH 11/3/43 1943 10³⁰ AM
21. I certify that death occurred on the date above stated, that I attended deceased from June 25 - 1943 to Nov 3 - 1943, and that I last saw him alive on Nov. 3 - 1943.
Immediate cause of death Acute Rheumatic Fever
Cardiac Hypertrophy about same history
Duration 20 yrs
Due to acute Rheumatic Fever 23 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Marshall Brown
Address 2125 Maryland Date signed 11/4/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 09818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 09818
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
Baltimore, Maryland
(b) Street address
(c) Hospital or institution:
Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *319 Forest Street*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ROBERT MYERS

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or
divorced

Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

1891

8. AGE:

Years

Months

Days

If less than one day

52

hr

min

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER12. Name *Richard Myers*13. Birthplace *Baltimore Md*14. Maiden Name *Sophie Dorsey*15. Birthplace *Baltimore*16 (a) Informant *Sarah Frederick*(b) Address *1617 Mc Elderry*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *5 5 43*

(month) (day) (year)

(c) Cemetery or crematory *Arbutus, M. Park.*Location *Arbutus Md*18 (a) Funeral director *Mrs Ida Bailey*(b) Address *1421 Jefferson St*19 (a) *NOV 5 - 1943*

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *NOV. 1,* 19 *43* at *11:10 A.* *M*

21. I certify that I took charge of the remains described above, held an
inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,
homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

*Fracture of skull, both
tibia and fibula*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:(a) Date of injury *10-31-43* at *12:40 A.* *5/1 M*(b) Where did injury occur? *Central Ave. & Fayette St*(c) Did injury occur at home, on farm, industrial place, in public
place? *Public Place* While at work? *No*(d) Means of injury *Pedestrian struck by auto.*23. Signature *W. L. Wallenmacher M.D.*

Medical Examiner.

Date signed *11-2-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

442986 09819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09819
Registered No.

1246

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2736 Reisterstown Rd**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2. (a) FULL NAME

Louis Pilot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Sep

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. **5-1-81**)

8. AGE: Years Months Days If less than one day
62 6 - hr. min.

9. Birthplace

MASS.

(Town, county, and state)

10. Usual Occupation

SALESMAN

11. Industry or business

MOTHER FATHER

12. Name **DAVID Pilot**

13. Birthplace **AUSTRIA**

14. Maiden Name **ANNA WEINBAUM**

15. Birthplace **AUSTRIA**

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

11-5-43

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

Hebrew Israel Cong.

Location

Elkridge Rd.

18 (a) Funeral director

Jace Lewis Inc

(b) Address

1439 E. Balto. St

19 NOV 5 - 1943

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov 1 1943**, at **6:55 P M**

21. I certify that death occurred on the date above stated; that I attended deceased from **OCT 16 1943**, to **NOV 1 1943** and that I last saw him alive on **NOV 1 1943**.

Immediate cause of death **Cardiac irregularity** Duration **arrest**

Due to **gallbladder disease**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **10-26-43**

Major findings of operation: **cholecystitis & cholelithiasis**

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Merle H. Hannel

Johns Hopkins Hosp

Date signed **11-2-43**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G. 09820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09820
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

Date filed by registrar

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

PHYSICIAN

Underline the name to which death should be charged statistically.

NOV. 5 1943

09821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09821
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. I. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

James W.

3 (b) If veteran, name war

3 (c) Social Security Account

No. 216-01-4637

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or

divorced Widower

6 (b) Name of husband or wife

Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 18-1920

8. AGE:

Years

23

Months

10

Days

15

If less than one day

hr.

min.

9. Birthplace

Dorchester Township Pa

(Town, county, and state)

10. Usual Occupation

Machine Operator

11. Industry or business

FATHER

12. Name

Lloyd Brittain

13. Birthplace

Pa

MOTHER

14. Maiden Name

Bessie Spielmeier

15. Birthplace

Pa

16 (a) Informant

Lloyd Brittain

(b) Address

Jones Creek

17 (a)

Burial

(b) Date thereof

Nov 6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn Cem

Location

Eastern Ave

18 (a) Funeral director

Geo M. Fink Don

(b) Address

811 N Wolfe St

NOV 5-1943

Huntington Williams M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Lincoln Ave + Jones Creek

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3

1943, at 2:50 PM

21. I certify that I took charge of the remains described above, held an

Inspection

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Crushed skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

Nov. 3rd 1943 at 2:15 PM

(b) Where did injury occur?

Lincoln Ave

(c) Did injury occur at home, on farm, industrial place, in public

place? Road

While at work? No

(d) Means of injury

auto ran into telephone pole

23. Signature

Robert L. Graham

M.D.

Date signed

Nov. 3 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09822

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 506 1/2 Patterson Park Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 506 1/2 Patterson Park Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Charles Dauterich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Charlotte Dauterich

6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.)

Aug 5/1863

8. AGE:

Years

Months

Days

If less than one day

90

2

29

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Sheet Metal Worker

11. Industry or business

Retired 18 yrs

12. Name

John Dauterich

13. Birthplace

Md

14. Maiden Name

Don't know

15. Birthplace

Md

16 (a) Informant

Charles L Allen

(b) Address

506 1/2 Patterson Park Ave

17 (a)

Burial

(b) Date thereof

Nov 6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn Cem

Location

City

18 (a) Funeral director

Relief Funeral Home

(b) Address

2004-8. Calver St

19 (a)

1943

(b) Huntington Hill

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1943 at 9 a M

21. I certify that death occurred on the date above stated and that I attended deceased from Nov 4 1943 and that I last saw him alive on Nov 4 1943

Immediate cause of death

Myocardial

Due to

Due to

Other conditions

General

Date of operation

Major findings at operation

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Dr. William Paul

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09823

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2130 Brookfield Ave.
(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 11

3 (a) FULL NAME Elizabeth Corinne Crawford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Willard F. Crawford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1863

8. AGE: Years 60 Months 7 Days 22 1 hr min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name James Francis Lucas

13. Birthplace Pa.

14. Maiden Name Elizabeth Sagafoss

15. Birthplace Md.

16 (a) Informant Elizabeth L. Crawford

(b) Address 2130 Brookfield Ave.

17 (a) Burial (b) Date thereof 11/5/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) NOV 5 - 1943

VS 180

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 Brookfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1943 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12, 1941, to Nov 2, 1943, and that I last saw her alive on Nov 2, 1943.

Immediate cause of death
Myocardial infarction 5 days
Due to Arterio Sclerosis 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies
Address 800 W. 33rd St. Date signed 11-7-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09824

BALTIMORE CITY HEALTH DEPARTMENT

G 09824

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Eliza Pearce
(c) Hospital or institution:
Southern Hospital & Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 YRS.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Eliza Pearce

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
female

5. Color or race
white

6 (a) Single, married, widowed, or
divorced. widowed

6 (b) Name of husband or wife Edward M. Pearce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1860

8. AGE: Years Months Days If less than one day
83 9 3 2 hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Abraham Mays

13. Birthplace

14. Maiden Name Syrupitia Wilhelm

15. Birthplace

16 (a) Informant Records - Southern Home

(b) Address 2510 Greenmount Ave.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Methodist Episcopal
Location Reisterstown, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) NOV 5 - 1943 (Date) (Registrar) Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 3 1943 at 11:55 M

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from 9-5-1943 to 11-3-1943,
and that I last saw her alive on 11-3-1943.

Immediate cause of death

Due to Chronic Myocarditis
Due to old age.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thurston Williams

M. D.

Address Medical Arts Bldg. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G 09825

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1609 Youngs Court

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Ida. Chester Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female colored

5. Color or race

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

Arthur Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 5, 1898

8. AGE: Years Months Days

If less than one day

45 5 28 hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

House wife

11. Industry or business

FATHER
MOTHER

12. Name

Dawson Chester

13. Birthplace

Baltimore, Md.

14. Maiden Name

Casper

15. Birthplace

Baltimore, Md.

16 (a) Informant

Arthur Thompson

(b) Address

1609 Youngs Ct

17 (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

11/6/43

Location

Mt. Calvary Cem.

18 (a) Funeral director

Joseph B. Locke

(b) Address

1344 N. Central Ave

19 (a)

(b)

(Date rec'd by registrar)

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1609 Youngs Court

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 3 1943 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1943 to Nov 3 1943 and that I last saw him alive on Nov 2 1943.

Immediate cause of death

Myocardial Insufficiency
Due to Cerebral Hemorrhage 20 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Edwards Fisher

1642 21 Monument Date signed 3/13

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 5 - 1943

G 09826
T.N

84364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G 09826
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James LeGrand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Bettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

? ? ? 50?

8. AGE:

Years

Months

Days

If less than one day

50?

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name Milton Le Grand

13. Birthplace N.C.

MOTHER

14. Maiden Name Sarah Spencer

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a)

Shipped

(b) Date thereof 11 - 5 - 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Chene House Cemetery

Location Mount of Dead N.C.

18 (a)

Funeral director William A. Jackson

(b) Address

916 Penna ave

19

5 - 1943

(b)

(Month) (day) (year)

Registrar

VS 120

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH

11 - 2

1943, at 12:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1943 to 11-2 1943, and that I last saw him alive on 11-2 1943.

Immediate cause of death

Bronchopneumonia

Due to

Deep Abdominal Carcinomatosis
Site of origin undetermined
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-28-43

Major findings of operation: Abdominal
carcinomatosis
of autopsy:

Duration

27 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Donald B. Webb

Address Baltimore City Hosp

Date signed 11-2-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09827

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **5227 CUTHBERT AVE.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) **27-18**

(e) Length of stay in Baltimore (yrs., mos., or days) **LIFE**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD.** (b) County
(c) City or town **BALTO.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **5227 CUTHBERT AVE**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **HARRIETT ELIZABETH KRAFT**

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

WIDOWED

6 (b) Name of husband or wife **GEORGE H. KRAFT**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **MAR 27-1867**

8. AGE: Years

76

Months

7

Days

76

If less than one day

hr.

min.

9. Birthplace **BALTIMORE, MARYLAND**

(Town, county, and state)

10. Usual Occupation

HOUSEWIFE

11. Industry or business

FATHER
MOTHER

12. Name

PETER BAUER

13. Birthplace

PENN

14. Maiden Name

UNKNOWN

15. Birthplace

16 (a) Informant **MRS. MARY F. WARD**

(b) Address **5227 CUTHBERT AVENUE**

17 (a) **BURIAL** (b) Date thereof **11-6-43**

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

LODON PARK

Location

FREDERICK AVE.

18 (a) Funeral director **C. RAYMOND HOFFMAN**

(b) Address **1026 LEEOS AVENUE**

NOV 5 - 1943

(b) **Huntington Williams, MD**

MEDICAL CERTIFICATION

20. DATE OF DEATH **11/3** 1943. at **6:40 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **OCT** 1943. to **NOV. 30** 1943. and that I last saw him alive on **NOV. 30** 1943.

Immediate cause of death

Arterio-sclerotic Cerebral

Due to

Diabetes Mellitus

Due to

Essential Hypertension

Other Conditions

Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Alex A. Wernstedt

Address **46030 K Hts Ave**

Date signed **11/4/43**

Duration

few years

few years

few years

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 09828

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belvedere & Greenspring Ave

(c) Hospital or institution:

Helena Home for Aged & Infirmed

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Belvedere & Greenspring
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jacob Silverman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Late Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Ladies Tailor

12. Name Solomon Silverman

13. Birthplace Russia

14. Maiden Name Meril ?

15. Birthplace Russia

16 (a) Informant Mrs Aaron Seligman

(b) Address 6805 Park Heights Ave

17 (a) Burial (b) Date thereof Nov, 5, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 (a) NOV 5 1943 (b) Huntington Williams, MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1943. at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27, 1943. to Nov. 4 1943. and that I last saw him alive on June 4, 1943.

Immediate cause of death

Acute coronary thrombosis

Due to

Due to

Other Conditions Chr. Bronchitis
Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Kevin

Address Levin's Dale

Date signed 11/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09829

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 1600 N. Caroline Street
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

John Walter Jenkins3 (b) If veteran, name war
None3 (c) Social Security Account
No. 212-07-24854. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of husband or wife Winifred Stran6 (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) Oct. 24th, 18938. AGE: Years 50 Months 0 Days 109 If less than one day
min.9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Funeral Director11. Industry or business George J. Ruth, Inc.
Undertakers12. Name Frank T. Jenkins13. Birthplace Baltimore Md.14. Maiden Name Mary L. Duff15. Birthplace Baltimore Md.16 (a) Informant Mrs. Winifred Jenkins (Wife)(b) Address 1600 N. Caroline Street17 (a) Burial (b) Date thereof Nov. 6, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto., Md.18 (a) Funeral director George J. Ruth, Inc.(b) Address 1735 Harford Avenue19 (a) Date of death Nov 5 - 1943
Washington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1600 N. Caroline St.(e) Citizen of foreign country? No (If yes, give location)(Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3rd, 1943 at 7:00 A.M.21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Sept 20 1943 to Nov 3 1943,
and that I last saw him alive on Nov 2 - 1943.

Immediate cause of death

Acute Dilatation of HeartDuration
2 daysDue to Chronic Myocarditis2 yrs

Due to

Other Conditions Bronchiectasis1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? _____ While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Gill HallAddress 1631 E North Ave Date signed Nov 7 1943

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 09830

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2332 N. Monroe St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

LENA ESLINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age 18 yrs

7. Birth date of deceased (mo., day, year)

8. AGE:

67

11

16

If less than one day

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

Housewife

12. Name

J. Stickel

13. Birthplace

Germany

14. Maiden Name

Wife Kufum

15. Birthplace

Germany

16 (a) Informant

Mrs A. M. Emmrich

(b) Address

2332 N. Monroe St

17 (a) Burial

Date thereof 11/6/43

(c) Cemetery or crematory

London Pk.

Location

1-2nd Ave

18 (a) Funeral director

Geo. B. Reinhardt

(b) Address

525 N. Pinehurst St

(c) Address

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Balto Md.

(d) Street No.

2332 N. Monroe St

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3

1943, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1943 to Nov 3 1943, and that I last saw her alive on Nov. 2 1943.

Immediate cause of death

Myocarditis

Due to

Parkinsonian Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Carl P. Rosling

Address 1376 H. Lombard St

Date signed 11/11/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09831

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1828 N. Collington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

Life

3 (a) FULL NAME

Godfrey H. Trill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5 Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Elizabeth Trill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 29 1869

8 AGE:

Years

Months

Days

If less than one day

74

2

5

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

11. Industry or business

retired Grocer

FATHER

12. Name

Godfrey Trill

13. Birthplace

Ger.

MOTHER

14. Maiden Name

Unknown

15. Birthplace

16 (a) Informant

Mrs. Elizabeth Trill

(b) Address

1828 N. Collington Ave

17 (a)

Burial

(b) Date thereof

9/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Baltimore

18 (a) Funeral director

Philip Herwig Sons

(b) Address

2024 Orleans St

19

NOV 5 1943

VB 130

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1828 N. Collington Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3

1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Nov 3 1943. and that I last saw him alive on Nov 3 1943.

Immediate cause of death

Lobar Pneumonia and Uremia

Due to

Due to

Other Conditions

Myocardial Insufficiency General Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Albert Cipeuberg

Address

2025 E North Ave

Date signed 11-4-43

19832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09832
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address 1514 Duvernay St
 (c) Hospital or institution: Providence Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County ---
 (c) City or town Baltimore City
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2143 Druid Hill Ave
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country ---

3 (a) FULL NAME

Gerald Stanley Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10.18.43

8. AGE: Years Months Days

89 hr. min.

9. Birthplace

Baltimore, Md
(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

12. Name

Andrew Johnson

13. Birthplace

Airmont, Va

14. Maiden Name

Elizabeth Johnson

15. Birthplace

Greenville, S.C.

16 (a) Informant

Andrew Johnson

16 (b) Address

2143 Druid Hill Ave

17 (a)

Retained by
(Burial, cremation, or removal) (month) (day) (year)

17 (c) Cemetery or crematory

Hospital for
Location

18 (a) Funeral director

Anatomical
(b) Address Purposes
(Date rec'd by registrar) 5-1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10.25.1943 at 1:30 M21. I certify that death occurred on the date above stated; that I attended deceased from 10.18.1943 to 10.25.1943, and that I last saw him alive on 10.25.1943.

Immediate cause of death

massive atelectasis,
left lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: atelectasis, left lung

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

M. D.

Address

Date signed

M. D.

Address

Date signed

M. D.

Address

Date signed

M. D.

Duration
4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Contact age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 5 - 1943

VS 150

SAVED FOR ANATOMICAL PURPOSES

09833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09833

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 24 N. Chapel St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 24 N. Chapel St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Paul J. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, '418. AGE: Years Months Days If less than one day
2 - 54 hr. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Andrew J. Dunn13. Birthplace Baltimore, Md.14. Maiden Name Elizabeth D. Danner15. Birthplace Baltimore, Md.16 (a) Informant Andrew J. Dunn(b) Address 24 N. Castle St.17 (a) Burial (b) Date thereof 11/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy RedeemerLocation Belair Rd.18 (a) Funeral director M. W. E. Dippel's Sons(b) Address Lombard & Ann Sts.19 (a) NOV 5 - 1943 (b) Huntington Williams, M.D.

(Date and by whom)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1943, at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH

Pneumonia

Due to

Purulent Meningitis
(Neuroci stained in smear)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed Nov. 4, 1943over

✓G 09S34
181 Registered No.

Registered No.

Chemicals in D Air handling system

H.L. Wallenchen und Carl Wadell

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09835
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

3 (a) FULL NAME

Robert Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 43

8. AGE: Years Months Days If less than one day
10 hr. min.

9. Birthplace Wm. H. B. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Dennis Williams

13. Birthplace Va.

14. Maiden Name Claude Champion

15. Birthplace Va.

16 (a) Informant Dennis Williams

(b) Address Gauder Court Fairfield

17 (a) Burial (b) Date thereof 11-5-43

(c) Cemetery or crematory Mt. Auburn

Location Bgto Md.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave

19 (a) (Date and day) 11-5-43

Registrar

11-5-43

11-5-43

11-5-43

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-1943 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1943 to 11-1-1943, and that I last saw him alive on 11-1-1943.

Immediate cause of death

Respiratory Failure

Due to cerebral hemorrhage

Due to bleeding from brain

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas P. Quinn

Address Wm. H. B. Md.

Date signed 11-5-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09836

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09836

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4 Sex

5. Color of race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

59

0

22

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

NOV 5 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M.D.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09837

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd

(c) Hospital or institution:

Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3807 Fernhill Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

William Henry Smith

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

widower

6 (b) Name of husband or wife Louise R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/1885

8. AGE: Years Months Days If less than one day

57

11

7

hr.

min.

9. Birthplace Canton, Ohio

(Town, county, and state)

10. Usual Occupation Ceramic Engineer

11. Industry or business Locke Insulator, Inc.

12. Name Edwin Herman Smith

13. Birthplace Manchester, N. Y.

14. Maiden Name Margaret Duffin

15. Birthplace Manchester, N. Y.

16 (a) Informant Mrs. Margaret R. S. Suchting

(b) Address 3807 Fernhill Ave.

17 (a) Burial (b) Date thereof 11/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1943 at 7:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1943 to 11/4 1943, and that I last saw him alive on 11/4 1943.

Immediate cause of death

Generalized peritonitis

Due to Intestinal perforation

Due to Intestinal obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/4/43

Major findings of operations: Generalized

peritonitis

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. B. Powers

Address Union Memorial Hosp.

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 5 1943

09838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH09838
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3909 Hayward Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)(d) Street No. 3909 Hayward Ave.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

FREDERICK ROGERS

3 (b) If veteran, name war

--

3 (c) Social Security Account

No. 705-09-2881

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1875

8. AGE: Years Months Days If less than one day

68

5

2

hr.

min.

9. Birthplace Pa.

(Town, county, and state)

10. Usual Occupation Retired Car Clerk

11. Industry or business B & O

12. Name James Rogers

13. Birthplace unknown

14. Maiden Name Catherine Fitzgerald

15. Birthplace Phila., Pa.

16 (a) Informant Mrs. Margaret Rogers

(b) Address 3909 Hayward Ave.

17 (a) Burial (b) Date thereof 11/8/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. Peters Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. Tiekner & Sons

(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1943 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Nov 4 1943, and that I last saw him alive on Nov 3 1943

Immediate cause of death

Miles Drooping

Due to

Dropsy,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Charles J. Miller

23. Signature Address 5276 Park Heights Date signed Nov 4, 43

Duration

6 mo

6 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS NOV 5 1943

G 09839

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09839
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-10-5374

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1943 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1943, to Nov 4 1943, and that I last saw him alive on Nov 4 1943.

Immediate cause of death

Duration

Coronary Occlusion

3 hrs

Due to

Cardio vascular disease

2 yrs

Due to

Acute Myocardial Infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

2025 S. Monument St

Date signed

11/4/43

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Ammie D. Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 24, 1884

8. AGE: Years

57

Months

6

Days

11

If less than one day

hr min.

9. Birthplace

Navada Mo.

(Town, county, and state)

10. Usual Occupation

Checker

11. Industry or business

Sergeant's Warehouse

12. Name

FATHER

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Date of registration

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09840
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1611 E. Balt. St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1

(e) Length of stay in Baltimore (yrs., mos., or days) 1 week

3 (a) FULL NAME Evelyn L. Poter

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5, 1937

8. AGE: Years Months Days If less than one day

6 7 67 - hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name James H. Poter

13. Birthplace W. C.

14. Maiden Name Mamie Clark

15. Birthplace Virginia

16 (a) Informant James H. Poter

(b) Address 1611 E. Balt. St.

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory West Norton
Location Virginia

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) (b) Registrar
NOV. 5 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1611 E. Balt. St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1943, 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4, 1943, to Nov. 5, 1943, and that I last saw him alive on 19

Immediate cause of death

Polar Pneumonia

Due to

Due to

Other Conditions History of recent ailments, pneumonia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Sinden

Address 14 S. Broadway Date signed Nov. 6, 1943

Duration

4 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX V G 09841
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M. D.

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 5 - 1943

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q 09842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09842

Registered No.

890

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date of registration)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 2 1948, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1948 to Nov 2 1948, and that I last saw her alive on Nov 2 1948.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed 11/3/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09843

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 9 S Robinson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Balti(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 9 S Robinson

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Charles A. Lauter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Freddie Lauter6 (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) Nov 2 - 18778. AGE: Years 66 Months — Days 2 If less than one day hr. min.

9. Birthplace

Germany
(Town, county, and state)10. Usual Occupation Refrigeration11. Industry or business Work12. Name George Lauter13. Birthplace Germany14. Maiden Name Don't know15. Birthplace Germany16 (a) Informant Henry L. Lauter(b) Address 12 N. Kenwood17 (a) Burial (b) Date thereof Nov 8/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak LawnLocation City18 (a) Funeral director Ulrich Funeral Home(b) Address 2845 S. OrleansNOV 5 - 1943 (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1943 at 7:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to Nov 4 1943, and that I last saw him alive on Nov 2 1943.

Immediate cause of death

Hypertensive C.V.R. Disease

Due to

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Allen P. LibermanAddress 229 N. Eldred Date signed 11/5/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH✓ G 09844
13a Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 600 S. Port Street
(c) Hospital or institution:

Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 31,
(If outside city or town limits, write RURAL and give town)(d) Street No. 600 S. Port Street
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Benjamin J. Novak

3 (b) If veteran, name war

World I

3 (c) Social Security Account
No. 214-202-5584. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married6 (b) Name of ~~husband~~ or wife Agnes Novak

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) ? 1899

8. AGE: Years Months Days If less than one day
44 hr. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sand Blaster

11. Industry or business Washington Navy Yard

12. Name Peter Novak

13. Birthplace Poznan Germany

14. Maiden Name Tinnie Hudzik

15. Birthplace Germany

16 (a) Informant Mrs. Agnes Novak (Wife)

(b) Address 600 S. Port Street

17 (a) Burial (b) Date thereof 11-9-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematorium ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A. Weber

(b) Address 705 S. Ann St

19 (a) Date of death NOV 5 1943 (b) Signature of physician

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1943 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Sept 8 1943 to Nov 4 1943.
and that I last saw him alive on Nov 4 1943.

Immediate cause of death

Myocardial Failure
Tuberculosis (lung)

Duration

1-

2-

Due to

schistosomiasis (?)

3 yrs +

Due to N.P. Schistosomiasis 10 yrs or
since about 3 yrs ago for chest infection

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the
cause to which
death should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work)

(e) Means of injury

23. Signature Leo F. Kulacki

Address 1265 S. Patterson St. Date signed Nov 5 1943

Kulacki

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09815
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(b) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2, 1943, to Nov 4, 1943, and that I last saw her alive on Nov 2, 1943.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed 4/4/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 5 1943

G 09846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09846

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **Wyman Park Drive & 31st St.**
 (c) Hospital or institution:
U. S. Marine Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) **6 hrs.**
 (e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
 (c) City or town **Baltimore**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **4201 Glenmore Avenue**
 (If rural give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

3 (a) FULL NAME **WILLIAM EUGENE KABLE**3 (b) If veteran, name war
World's War3 (c) Social Security Account
No. -

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**

6 (b) Name of husband or wife **Sadie Larkins**
 6 (c) If alive, give age **40** years

7. Birth date of deceased (mo., day, yr.) **Aug. 14, 1899**

8. AGE: Years **44** Months **2** Days **21** **20** hr. min.

9. Birthplace **Baltimore, Md.**
 (Town, county, and state)

10. Usual Occupation **Band Leader Protection**

11. Industry or business

12. Name **Clarence Kable**
 13. Birthplace **Charlestown, W.Va.**

14. Maiden Name **Ellen Dvdrow**
 15. Birthplace **W.Va.**

16 (a) Informant **Records, U.S. Marine Hosp.**
 (b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **11-8-43**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Parkwood**
 Location

18 (a) Funeral director **Lionel May**
 (b) Address **5-1943 S. Huntingon**

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **November 4, 1943** at **10:20** **A.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 4, 1943** to **Nov. 4, 1943**, and that I last saw him alive on **Nov. 4, 1943**.

Immediate cause of death **Cerebral hemorrhage**

Duration
6 hrs.

Due to **Hypertensive cardiovascular disease**

Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operations

of autopsy: **Not done**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide **No**
 (b) Date of occurrence at **M**
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**

(e) Means of injury **Heart**

Address **Baltimore, Md.** Date signed **11/4/43**

09847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09847
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4108 Oakford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Oakford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Grace Coates Selby.

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced Widowed.

6 (b) Name of husband or wife

Lee Selby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1876

8. AGE: Years Months Days If less than one day
67 1 16 15 hr. min.

9. Birthplace Richmond, Va.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Thomas Coates

13. Birthplace England

14. Maiden Name Dorinda A. Wright

15. Birthplace Petersburg, Va.

16 (a) Informant Mrs. Edward W. Berry

(b) Address 4108 Oakford Avenue

17 (a) Burial (b) Date thereof Nov. 6 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director William L. Lawrence

(b) Address 4510 Liberty Heights Avenue

NOV 5 - 1943
Date rec'd

MEDICAL CERTIFICATION

12.10

20. DATE OF DEATH Nov. 4th 1943 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1943 to Nov. 4 1943, and that I last saw her alive on Nov. 4 1943.

Immediate cause of death

Inoperable Carcinoma
of Colon and Kidney
Due to above condition was
discovered about May 15/43.
Due to it was then inoperable.Other Conditions Carcinoma of
Colon

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Water & Toilet

23. Signature

M. D.

Address 2220 Garrison Blvd. Date signed

09848

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09848

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A?

years

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(c) Hunter for

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/43 to 11/15/43 and that I last saw her alive on Nov 15 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address

M. D.

Date signed

09849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09849
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *201 W. West St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *23*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *201 W. West St*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME

Catherine A. Kearns

3 (b) If veteran, name war:

3 (c) Social Security Account

No.

4. Sex

Fem.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

*widow*6 (b) Name of husband or wife *Timothy J.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 1-1880*

8. AGE: Years Months Days If less than one day

*63**7**4*

hr.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name *Dionisius Jean*13. Birthplace *Ireland*

MOTHER

14. Maiden Name *Mary A. Rooney*15. Birthplace *Ireland*16 (a) Informant *Edw. Kearns*(b) Address *201 W. West St*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof *Nov. 8, 1943*

(month) (day) (year)

(c) Cemetery or crematory *Balto. National Cem*Location *Frederick Rd.*18 (a) Funeral director *Fred. A. House & Son*(b) Address *246 S. Charles St*

NOV 5 - 1943

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/5/43* 19 *8:15 AM*21. I certify that death occurred on the date above stated that I attended deceased from *Sept 1943* and that I last saw him alive on *11/5/43*

Immediate cause of death

Cancer of stomach

Duration

Sept 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Spase Miller*Address *122 S. Charles St*Date signed *11/5/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

09850

T.N

30812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09850

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 4940 Eastern Ave
 (c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
 (e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3738 Gough St
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

August H Reiter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Marie Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1889

8. AGE: Years 53 Months 10 Days 21
 If less than one day
 hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

Salesman

11. Industry or business

12. Name Henry Reiter

13. Birthplace

14. Maiden Name Marie E. Dumer

15. Birthplace Maryland, Baltimore County

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 11/6/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave., Parkville.

18 (a) Funeral director John J. Connelly

(b) Address 418 Eastern Ave. City

NDV 5-1943 Huntington Williams, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1943 at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1938 to 11-3 1943, and that I last saw him alive on 11-3 1940.

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul Mattner

M. D.

Address B.C. H.

Date signed 11-4-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09851
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address *Redwood & Green Sts.*
 (c) Hospital or institution: *University Hospital*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*
 (e) Length of stay in Baltimore (yrs., mos., or days) *2 mo.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *2301 Redwood Lane*
 (If rural give location)
 (e) Citizen of foreign country? *yes* (Yes or No)
 If yes, name country

3 (a) FULL NAME

Joseph J. Geiler Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

infant

6 (b) Name of husband or wife

none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 30 1943

8. AGE:

Years

Months

Days

If less than one day

*2 mo**3*

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

FATHER
MOTHER

12. Name

Joseph Geiler

13. Birthplace

Balto. Inf.

14. Maiden Name

Teresa Bushheit

15. Birthplace

Balto. Md.

16 (a) Informant

Joseph Geiler Jr.

(b) Address

*2301 Redwood Lane*17 (a) *Burial*

(Burial, cremation, or removal)

(b) Date thereof

Nov. 6 1943

(c) Cemetery or crematory

Ass. Cathedral

Location

Baltimore, Md.

18 (a) Funeral director

George L. Schwalb

(b) Address

2101 E. Federal Ave.

NOV 5 - 1943

(Date rec'd by registrar)

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-3-43

19

2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from *11-1-43* 19 to *11-3-43* 19, and that I last saw him alive on *11-3-43* 19.

Immediate cause of death

myocardial infarction, old; coronary artery disease

Duration

7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Raymond J. C. Kangle

Address

University Hospital

Date signed

11-3-43

09852

HEALTH DEPARTMENT—CITY OF BALTIMORE

09852

CERTIFICATE OF DEATH

✓937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2715 - Monument St. Ward)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Louise M. Kraus

(a) Residence: No. 2715 E. Monument St. 7-2 Ward

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

U. S. Veteran
specify WAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color of Race White 5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced, name of husband or (for) WIFE of John V. Kraus

6. DATE OF BIRTH (month, day, year) Sept. 16, 1866

7. AGE Years 77 Months 1 Days 18 1/2 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country)

13. NAME Nicholas Hoffman

14. BIRTHPLACE (city or town) France (State or country)

15. MAIDEN NAME Margaret Long

16. BIRTHPLACE (city or town) Germany (State or country)

17. INFORMANT John V. Kraus (Address) 2715 E. Monument St.

18. BURIAL, CREMATION, OR REMOVAL Place Burial St. Mary's Cemetery 11/6 1943

19. UNDERTAKER Wendell E. Humphreys (Address) 1501 Broadway

20. SIGNATURE (Address) Huntington Williams, M.D.

NOV 6 - 1943

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 3, 1943

22. I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1942, to Nov. 3, 1942

I last saw him alive on Nov. 3, 1942 Death is said to have occurred on the date stated above, at 11:45 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Hypertension.

Other contributory causes of importance:

Hypertension.

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur?

Specify whether injury occurred in industry, in home, or in public place (Specify city or town, county, and State)

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) W. S. Johnson M. D.

(Address) 701 N. Kentwood Ave.

G 09853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09853

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

2328 E. Hoffman St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

6 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

2328 E. Hoffman St

(If rural, give location)

(e) If foreign born, how long in U. S. A?

years

3 (a) FULL NAME

Baby Charles Lee Plivier

3 (b) If veteran, name was

3 (c) Social Security Account

No. 02-08

4. Sex

M

5. Color of face

W

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1943

8. AGE:

Years

Months

Days

If less than one day

1

12

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Charles Frederick Plivier

MOTHER

13. Birthplace

Baltimore, Md.

14. Maiden Name

Thelma Dorothy Abbott

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mrs. Thelma Plivier

(b) Address

2328 E. Hoffman St

17 (a)

Burial

(b) Date thereof

11/6/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location

Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

NOV 6 - 1948

Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 5

1943

at 9:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/23 1943 to 11/5 1943, and that I last saw him alive on 11/4 1943.

Immediate cause of death

premature birth -
cadaveria

Due to

gastro-intestinal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

L. C. St. John

Address

447 N. Kenwood Ave

Date signed 11/6/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09854

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 343 Stoney Run Lane(c) Hospital or institution: McKenna Memorial Nursing Home(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 mos.(e) Length of stay in Baltimore (yrs., mos., or days) 11 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 Northern Parkway

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Duncan Mac Neill

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. None

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Widowed6 (b) Name of husband or wife Quinn Mac Neill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr. Aug 23rd 18638. AGE: Years 80 Months 2 Days 11 hr. min.9. Birthplace Nova Scotia

(Town, county, and state)

10. Usual Occupation Retired11. Industry or business Carpenter12. Name John Mac Neill13. Birthplace Nova Scotia14. Maiden Name Jessie Mac Donald15. Birthplace Nova Scotia16 (a) Informant Miss Evelyn Negarty(b) Address 2502 W. Lenoire St17 (a) Burial (b) Date thereof 11/6/43

(Burial, cremation, or other)

(c) Cemetery or crematory London ParkLocation Balto. Md.18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul StHuntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1943 at 9³⁰ p.m.21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Nov 4 1943 and that I last saw him alive on Nov 4 1943

Immediate cause of death

Cerebral hemorrhageDue to Arterio sclerosisDue to Chronic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas U. GoadAddress 735 N. Fulton StDate signed 11/5/43

Duration

5 days10 yrs12 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09855
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mo.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1508 E Pratt St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Male

5. Color or race

negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

? 94?

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

UNIVERSITY MEDICAL SCHOOL NOV 5 1943

18 (a) Funeral director

Commissioner of Health

19

(b) Address

NOV 6 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 3, 1943, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1943 to Nov 3 1943, and that I last saw him alive on Nov 3 1943.

Immediate cause of death

Bronchopneumonia
Probably 1 or 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. B. Bannister

Address

Robert Hospital

Date signed 11/4/43

M. D.

09856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09856
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 5921 Sefton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-4

(e) Length of stay in Baltimore (yrs., mos., or days):

3 (a) FULL NAME

Alexander Gelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Catherine Gelli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-1882

8. AGE: Years Months Days If less than one day
61 1 2 hr. min.

9. Birthplace

Italy

(City, county, and state)

10. Usual Occupation

Shoe Repairing

11. Industry or business

FATHER
MOTHER

12. Name

Anthony Gelli

13. Birthplace

Italy

14. Maiden Name

Anna Celani

15. Birthplace

Italy

16 (a) Informant

Catherine Gelli

(b) Address

5921 Sefton Ave

17 (a)

Burial

(b) Date thereof 11-8-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

18 (a) Funeral director

Leonard J. Rush

(b) Address

5305 Harford Road

NOV 6 1943

(b) Hunterdon Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

5921

Sefton Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1943, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1941 to Nov 4 1943, and that I last saw him alive on Nov 4 1943.

Immediate cause of death

Coronary Thrombosis
Arteriosclerosis cardiovascular

Due to aortic disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

Calumet

23. Signature

Address

6217 Harford

Date signed

11/5/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G 09857

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Saratoga & Calvert Sts.*

(c) Hospital or institution:

Murphy Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 days*(e) Length of stay in Baltimore (yrs., mos., or days) *17 days*

3 (a) FULL NAME

Wayne Edward Ullrich

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W.

6 (a) Single, married, widowed, or

divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *Oct 20, 1943*

8. AGE: Years Months Days If less than one day

17

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John F. Ullrich

13. Birthplace

Baltimore, Md.

14. Maiden Name

Kathleen Anderson

15. Birthplace

Baltimore, Md.

16 (a) Informant

(b) Address

*Record Murphy Hosp.*17 (a) *Burial* (b) Date thereof *11-6-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

18 (a) Funeral director

Leonard F. Rust

(b) Address

5305 Woodford Rd

NOV 6 - 1943

(Date filed by Registrar)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

Baltimore

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

*5911**Bertram Ave*

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 5, 1943, at 5:45 PM*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *Nov 2, 1943, to Nov 5, 1943,*and that I last saw him alive on *Nov 5, 1943.*

Immediate cause of death

Cardio-Respiratory Failure

Duration

3 days

Due to

Bronchitis

Due to

Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Edward Wayne Lee, M.D.

Address

Date signed

09858

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

09858

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Street address

Hospital or institution:

Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 718 S. Power St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Margaret J. Schenk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1943

8. AGE: Years Months Days If less than one day

6

16

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Frederick J. Schenk13. Birthplace Baltimore, Maryland14. Maiden Name Margaret J. Bradford15. Birthplace Baltimore, Maryland16 (a) Informant Margaret J. Schenk(b) Address 718 S. Power Street17 (a) Burial (b) Date thereof 11/6/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Q. Donnell Eastman18 (a) Funeral director Bluma F. Hoffman(b) Address 1637 N. BroadwayHuntington, Md.

NOV 6 - 1943 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1943, at 5:55 PM

21. I certify that I took charge of the remains described above, held an

autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to her death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Stasis Thymuslymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury

23. Signature Robert L. Fulem M.D.Date signed November 4, 1943

PLACING WRITING FAINTLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09859

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 749 W. Saratoga St.

(c) Hospital or institution:

University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Fla. (b) County

(c) City or town 2 Deerfield Beach (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

John Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11/1/1943

8. AGE:

Years

Months

Days

If less than one day

50

hr.

min.

9. Birthplace

Florida

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name

Tom Brooks

13. Birthplace

Florida

MOTHER

14. Maiden Name

Victoria Graham

15. Birthplace

Florida

16 (a) Informant

(b) Address

17 (a) Shipped

(b) Date thereof 11/6/43

(c) Cemetery or crematory

Deerfield Beach

Location

Florida

18 (a) Funeral director

Mr. Ida Bailey

(b) Address

1421 Jefferson St.

19 (a) Date of death

11/6/43

20 (a) Date of death

11/6/43

21 (a) Date of death

11/6/43

22 (a) Date of death

11/6/43

23 (a) Date of death

11/6/43

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/1943 at 12:22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/1943 to 11/3/1943, and that I last saw him alive on 11/3/1943.

Immediate cause of death

Cardiac Decompensation

Due to Debilitated State

Due to Chronic Lymphoid

Leukemia

Other Conditions Terminal Labor

pneumonia, etc.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Francis J. Ruzicka Jr.

Address University Hosp. Date signed 11/6/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 6 1943

09860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

G 09860

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 2942 Wyman Parkway
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Balto.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2942 Wyman Parkway
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

GEORGE W. DAVIS

3 (b) If veteran, name war
none3 (c) Social Security Account
No. none4. Sex
male5. Color or race
white6 (a) Single, married, widowed, or
divorced. widower

6 (b) Name of husband or wife Florence B. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1862

8. AGE:	Years	Months	Days	If less than one day
	81	2	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cotton Broker - Retired

11. Industry or business Wm. Anderson Co., N. Y.

12. Name Wm. J. Davis

13. Birthplace Md.

14. Maiden Name Sarah Cook

15. Birthplace Md.

16 (a) Informant Miss Audrey W. Davis

(b) Address 2942 Wyman Parkway

17 (a) Burial (b) Date thereof 11/6/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

NOV 6 1943

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1943, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended
 deceased from Oct 26 1943 to Nov 3 1943.
 and that I last saw him alive on Nov 3 1943

Immediate cause of death

Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address 2105 Ebas

Date signed Nov 5 1943

Duration
2 yrs

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

PREPARE WITH CARE, WITH ONE ADJACENT LINE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 09861

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Wyman Park Drive and 31st St.
- (c) Hospital or institution:
US Marine Hospital, Baltimore, Maryland.
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo 15da
- (e) Length of stay in Baltimore (yrs., mos., or days) 2mo 15da

2. USUAL RESIDENCE OF DECEASED:

- (a) State Maryland (b) County Somerset
- (c) City or town Princess Anne
(If outside city or town limits, write RURAL and give town)
- (d) Street No. Route 2
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN FRANKLIN LEWIS

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. -----

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Edna Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/24/73

8. AGE: Years Months Days If less than one day

70 7 11 hr. min.

9. Birthplace VENTON, MARYLAND

(Town, county, and state)

10. Usual Occupation Mate

11. Industry or business

12. Name William J. Lewis

13. Birthplace Delaware

14. Maiden Name Mary J. Phoebus

15. Birthplace Venton, Maryland

16 (a) Informant Records-US Marine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 11-8-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Princess Anne

Location Princess Anne, Md.

18 (a) Funeral director Durward S. Coughton

(b) Address 21 W. 25th St.

NOV 6 - 1943

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1943 at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20, 1943 to Nov. 5, 1943, and that I last saw him alive on Nov. 5, 1943.

Immediate cause of death

Adenocarcinoma of stomach

Duration

Unk.

Due to

Due to

Other Conditions

(Include previous illness, if any)

Date of operation 9/6/43-10/12/43

Major findings of operation: Jejunostomy;

Venoclysis, Exp. Lap; Ant. Gastrojejunostomy; Jejunostomy-Venoclysis.

of autopsy: None

PHYSICIAN

Underline the cause to which charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
- (e) Means of injury
23. Signature *[Signature]*

Address US Marine Hospital Baltimore, Md.

Date signed 11/6/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09862
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 3330 Ravenwood Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

female

5. Color of race

white

6 (a) Single, married, widowed, or divorced

widow

6 (b) Name of husband or wife Edward E. Hanton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15, 1875

8. AGE: Years Months Days If less than one day

68 6 21 0 hr. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation house work11. Industry or business at home12. Name John. Sebold13. Birthplace Baltimore14. Maiden Name Mary. Greer15. Birthplace Baltimore16 (a) Informant Mr. Frank B. Weber(b) Address 3330 Ravenwood Ave.17 (a) burial (b) Date thereof 11/8/43(c) Cemetery or crematory St. Peter's ChurchLocation 1300 Maryland Ave.18 (a) Funeral director John Cowan & Son(b) Address 901 E. Fellows StreetDate received Nov 6 - 1943

2. USUAL RESIDENCE OF DECEASED:

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3330 Ravenwood Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5, 1943 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended

deceased from 1935 to 11-5-1943and that I last saw her alive on 11-5-1943

Immediate cause of death

Pulmonary EdemaDue to acute dilation of heartDue to Chronic Valvular heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Milton E. LangAddress 2117 Belair Rd Date signed 11-5-43

M. D.

Huntington

by Thomas J. Leveaux, M.D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

9863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09863

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Duhaland & Rayner Ave.*

(c) Hospital or institution:

West Balto. Gen. Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *17 days*(e) Length of stay in Baltimore (yrs., mos., or days) *37 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.* (b) County(c) City *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *5118 Cordelia Ave.* (If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Harry Pucci

3 (b) If veteran, name war

none

(c) Social Security Account

No. *216-05-0255*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

*married*6 (b) Name of husband or wife *Frances Pauline Pucci*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Nov. 17 1888*

8. AGE: Years Months Days If less than one day

*54 11 18 17 hr. min.*9. Birthplace *Ascoli Piceno Italy*

(Town, county, and state)

10. Usual Occupation *Tailor*11. Industry or business *Tailor Shop*12. Name *Luigi Pucci*13. Birthplace *Italy*14. Maiden Name *Giuseppina Poppe*15. Birthplace *Italy*16 (a) Informant *Frances P. Pucci (Wife)*(b) Address *5118 Cordelia Ave*17 (a) *Burial* (b) Date thereof *Nov. 8 1943*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *New Cathedral Cem.*
Location *4300 old Frederik Rd, Balt. Md.*18 (a) Funeral director *Frank Della Hore*(b) Address *52 N. Morley St.*

NOV 6 1943

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MEDICAL CERTIFICATION

20. DATE OF DEATH *November 4 1943, 11 A.M.*21. I certify that death occurred on the date above stated; that I attended deceased from *10/18 1943* to *11/4 1943*, and that I last saw him alive on *11/4 1943*.

Immediate cause of death

Myocardial Infarction
Due to *Carcinoma of Stomach*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *10/29/43*Major findings of operations: *Carcinoma of Stomach (?)*

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *William M. Cheek*Address *D. B. G. H.* Date signed *11/9/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09864

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1312 G 09864
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive and 31st St.,**
(c) Hospital or institution: **US Marine Hospital, Baltimore, Md.**
(d) Length of stay in hospital or inst. (yrs., mos., or days) **13 da.**
(e) Length of stay in Baltimore (yrs., mos., or days) **1 year**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Maryland** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2400 E. Federal Street**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3 (a) FULL NAME

GEORGE LOUIS KILGUS

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **May 28, 1900**

8. AGE:

Years

Months

Days

If less than one day

43

5

6

hr.

min.

9. Birthplace **WESTBURY, MASS.**

(Town, county, and state)

10. Usual Occupation **SEAMAN**

11. Industry or business

12. Name **George Kilgus**

13. Birthplace **Germany**

14. Maiden Name **Katherine Fiend**

15. Birthplace **Germany**

16 (a) Informant **Records-US Marine Hospital**

(b) Address **Baltimore, Md.**

17 (a) **Burial** (b) Date thereof **11-8-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Baltimore Cemetery**
Location **Baltimore Md**

18 (a) Funeral director **Albert L. Hill Jr.**

(b) Address **1100 N. Chester St.**

19 **NOV 6 - 1943** (Date rec'd by registrar) **Thurston Williams M.D.**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 4, 1943** at **8:00 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 21, 1943** to **Nov. 4, 1943**, and that I last saw him alive on **Nov. 4, 1943**.

Immediate cause of death **Uremia**

Duration
1 wk.

Due to **Chronic glomerulo nephritis**

Unk.

Due to **Hypertensive cardiovascular disease**

Unk.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: **None**

of autopsy: **None done**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify part of place)

(e) Means of injury

23. Signature **J. C. Hill**

Address **US Marine Hospital** Date signed **11/5/43**
Baltimore, Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

09865

09865

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2502 Druid Hill Ave St. 13-3 Ward)

Registered No. _____

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

Length of residence in city or town where death occurred: yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME

(a) Residence: No. 2502 Druid Hill Ave St. 13-3 Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. Color or Race Col 5. Single, Married, Widowed, or Divorced (write the word) Married6a. If married, widowed or divorced HUSBAND of Agnus Parker (or) WIFE of6. DATE OF BIRTH (month, day, year) Aug 20, 18867. AGE Years 57 Months 2 Days 14 If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ✓
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓
10. Date deceased last worked at this occupation (month and year) ✓ 11. Total time (years) spent in this occupation ✓12. BIRTHPLACE (city or town) Maryland (State or country)13. NAME William Parker14. BIRTHPLACE (city or town) Maryland (State or country)15. MAIDEN NAME Unknown16. BIRTHPLACE (city or town) ✓ (State or country)17. INFORMANT Agnus Parker (Address) 2502 Druid Hill Ave18. BURIAL, CREMATION, OR REMOVAL Place Int. Ashbury Date 11/219. UNDERTAKER Geo. H. Kelsay (Address) 1503 Pleasant St20. FILED 18 William H. Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 4, 194322. I HEREBY CERTIFY, That I attended deceased from Oct 24 1943 to Nov 4 1943I last saw him alive on Nov 4, 1943 Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic interstitial nephritis hypertension

Other contributory causes of importance

Was an operation performed? ✓ Date of ✓For what disease or injury? ✓Name of operation Op. EyWhat test confirmed diagnosis? ✓ Was there an autopsy? ✓23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? ✓ Date of injury ✓Where did injury occur? ✓ (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place ✓Manner of injury ✓Nature of injury ✓24. Was disease or injury in any way related to occupation of deceased? ✓(Signed) R. G. Ford M. D.(Address) 1534 - Druid Hill Ave

NOV 6 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09866

CONNER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09866
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 664 W. Sandberg
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mo., or days)

(e) Length of stay in Baltimore (yrs., mo., or days) 3 yrs

3 (a) FULL NAME

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 6 - 1943

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/5

1943 1245 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 to 11/5, 1943, and that I last saw him alive on 11/5, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HORSEY

G 09867
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 6 1943

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2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 4 1943

at 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to Nov 4 1943.

and that I last saw him alive on Nov 4 1943.

Immediate cause of death

Myocardial infarction

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date of death

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09868

DORSEY
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09868**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **416 Ogden**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MD** (b) County
(c) City or town **Baltimore**
(If outside city or town, limit to RURAL and give town)
(d) Street No. **416 Ogden** (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Evans Dorsey

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex **Female** 5. Color or race **Col.** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Lea Dorsey**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Oct. 2, 1890**

8. AGE: Years **53** Months **1** Days **1** If less than one day hr. min.

9. Birthplace **Washington D. C.**
(Town, county, and state)

10. Usual Occupation **Housewife**

11. Industry or business

FATHER 12. Name **Allen - Johnson**

13. Birthplace **Va.**

MOTHER 14. Maiden Name **Edna ?**

15. Birthplace **Va.**

16 (a) Informant **Arbutus Raley**
(b) Address **316 N. Bruce St.**

17 (a) **Burial** (b) Date thereof **Nov. 6, 1943**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Arbutus Mem.**
Location

18 (a) Funeral director **Mr. Katie R. Williams**
(b) Address **316 N. Bruce St.**

19 (a) **NDV 6 - 1943** (b) **Huntington Williams, M.D.**
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov 7 1943** **12:30 P**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct 24 1943** to **Nov 3 1943** and that I last saw him alive on **Nov 7 1943**

Immediate cause of death **Leukemia** Duration **6 mo**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **[Signature]**

Address **416 Ogden** Date **Nov 6 1943**

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

937

G 09859

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1811 W. Franklin St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

3 (a) FULL NAME

Isaac H. Shepp.

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Irene L. Shepp.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1877.

8. AGE: Years Months Days If less than one day

66

0

20

hr.

min.

9. Birthplace Elkton - Va.

(Town, county, and state)

10. Usual Occupation Retired Bakery -

11. Industry or business - Salesman

12. Name Charles N. Shepp.

13. Birthplace Va.

14. Maiden Name Mary J. Kaufman.

15. Birthplace Va.

16 (a) Informant Mrs. Irene L. Shepp.

(b) Address 1811 W. Franklin St.

17 (a) Removal (b) Date thereof Nov. 6 43.

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Evergreen Cemetery.

Location Bladensburg, Md.

18 (a) Funeral director Charles J. Scholz.

(b) Address 505 N. Madison St.

Thurston, Williams, Md.

19 (a) Date of death Nov 7 1943

(b) Time of death 6:45 AM

(c) Cause of death

(d) Manner of death

(e) Signature

(f) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.

(d) Street No. 1811 W. Franklin St.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

(f) Date of death November 6, 1943 at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1940, to Nov 6, 1943, and that I last saw him alive on Nov 6, 1943.

Immediate cause of death

cardiac asthma.

Due to Cardiac Asthma

Due to Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. J. Smith

Address 506 N. Fulton St.

Date signed Nov 6 1943

M. D.

Physician

Underline the cause to which death should be charged statistically.

Duration

1 hr.

2 yrs

3 yrs

4 yrs

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09870

Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address *Green & Redwood St*

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mo., or days) *1 1/2 days*(e) Length of stay in Baltimore (yrs., mo., or days) *1 1/2 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md*(b) County *Carroll*(c) City or town *Westminster*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Rt 5*

(If rural give location)

(e) Citizen of foreign country? *no*

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Myerly

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

single

6 (b) Name of husband or wife

infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 1943

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual Occupation

infant

11. Industry or business

FATHER

12. Name

James Myerly

13. Birthplace

MOTHER

14. Maiden Name

Malden

15. Birthplace

16 (a) Informant

mother (Malden Myerly)

(b) Address

Rt 5 Westminster Md

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

11/8/43

(c) Cemetery or crematory

Stone Chapel

Location

Westminster Md

18 (a) Funeral director

W. Sharper & Son

(b) Address

Westminster Md

NOV 7 - 1943

Huntington Williams, 11/8

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-6-43

19

*6:15 P.*21. I certify that death occurred on the date above stated; that I attended deceased from *11-5-43* to *11-6-43* 19*43*, and that I last saw him alive on *11-6-43* 19*43*.

Immediate cause of death

Jaundice & edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. Sharper & Son

Address

University Hospital

Date signed

11-6-43

Duration

*about**2 weeks*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09871

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Belvedere & Greenup*

(c) Hospital or institution:

Hebrew Home for Aged & Infirmary(d) Length of stay in hospital or inst. (yrs., mos., or days) *3 mos*(e) Length of stay in Baltimore (yrs., mos., or days) *37*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Belvedere & Greenup*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Jacob Suls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

*white*6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Late Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1883

8. AGE: Years

60

Months

Days

If less than one day

hr.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

*Tailor*FATHER
MOTHER12. Name *Hyman Suls*13. Birthplace *Poland*14. Maiden Name *Eva ?*15. Birthplace *Poland*16 (a) Informant *Benjamin Suls*(b) Address *4010 Dorchester Road*17 (a) *Burial*(b) Date thereof *Nov 7, 1943*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

*Workmen Circle Cemetery*Location *German Hill Road*18 (a) Funeral director *Sol Levinson & Bros*(b) Address *1124 1126 W North Ave*

19 (a)

*1943**Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 5* 19*43*, at *12:00 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Aug 13* 19*43*, to *Nov 5* 19*43*, and that I last saw him alive on *Nov 5* 19*43*.

Immediate cause of death

*Coronary thrombosis
Hypertension, Atherosclerosis*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edmund L. Hever

Address

*Levendale*Date signed *7/1/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTING, WITH UNFADING INK. Every item of information should be carefully supplied. Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 7 - 1943

VS 114

G 09872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09872

Registered No.

50

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

38th St.

(c) Hospital or institution:

Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

4 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL, and give town)

(d) Street No. 1215 Cutaw Place

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. ~~Joseph~~ (Regina) Cahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

W

6 (b) Name of husband or wife

Joseph Cahn.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 7, 1879

8. AGE:

Years

Months

Days

If less than one day

64

1

28

hr.

min.

9. Birthplace

Massachusetts.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Adolph Wolfe

13. Birthplace

Germany.

14. Maiden Name

Rosa

15. Birthplace

Germany

16 (a) Informant

HOSP. RECORDS

(b) Address

17 (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof 11-7-43

(month) (day) (year)

(c) Cemetery or crematory

HEBREW FRIENDS

Location BALTO T CONKLIN STS

18 (a) Funeral director

JACK LEWIS INC.

19 (a) NOV 7 1943

1200 EUTAW PLACE

(b) Date rec'd by registrar

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 5 1943, at 6⁰⁰ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1943, to Nov. 5 1943, and that I last saw her alive on Nov. 5 1943.

Immediate cause of death Respiratory and Cardiac Failure

Due to Carcinomatosis

Due to Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John A. Harbitt, Jr.

M. D.

Address Union Memorial Hosp. Date signed 11-5-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09873

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Monument St.*
 (c) Hospital or institution: *Sinai Hosp.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *6-4*
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County
 (c) City or town *Balto.*
 (If outside city or town limit, write RURAL and give town)
 (d) Street No. *115 N. Wolfe St.*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

LOUIS HANKOFSKY

3 (b) If veteran, name war

3 (c) Social Security Account
No. *-*4. Sex *M*

5. Color or race

MALE WHITE

6 (a) Single, married, widowed, or divorced.

*MARRIED*6 (b) Name of husband or wife *SARA*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE: Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual Occupation

NONE

11. Industry or business

FATHER

12. Name

ISAAC HANKOFSKY

13. Birthplace

RUSSIA

MOTHER

14. Maiden Name

LIBA

15. Birthplace

RUSSIA

16 (a) Informant

HOSP. RECORDS

(b) Address

17 (a) *BORIAL*(b) Date thereof *11-7-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

MT. ST. + GERMAN HILL R.

Location

Jack Lewis Inc

18 (a) Funeral director

*1439 E. Balto St.**NOV 7-1943*

(Date rec'd by registrar)

Hastington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/4/43* 19 *43* at *11:45* AM21. I certify that death occurred on the date above stated; that I attended deceased from *10/14/43* to *11/4/43* and that I last saw him alive on *11/4/43*Immediate cause of death *Cancer*

Duration

Due to *Peritoneal Carcinomatosis*Due to *C. of Stomach*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation *7/15/43*

Major findings of operations:

Peritoneal Carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature *Raymond B. Holbey*Address *Sinai Hosp.*Date signed *11/6/43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09874

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2124 Ashton St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 49

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female White

Widowed

6 (b) Name of husband or wife Hyman Kramel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 68 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Huntsman

11. Industry or business

12. Name Harry Kallinsky

13. Birthplace Russia

14. Maiden Name Mully-

15. Birthplace Russia

16 (a) Informant Harry Specter

(b) Address 2124 Ashton St

17 (a) Burial (b) Date thereof 11-7-43 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem Location Washington Blvd

18 (a) Funeral director Joseph Weiss Inc

(b) Address 1439 E. Baile St

19 (a) Date of death Nov 7 1943 (b) Huntington Hills, Md Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balti (If outside city or town limits, write RURAL and give town)

(d) Street No. 2124 Ashton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-43 19 43 at 5:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1943 to Nov 7 1943 and that I last saw her alive on Nov 6 1943.

Immediate cause of death Cancer of stomach

Duration 145

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(a) Means of injury

23. Signature Harry S. McCarty M. D.

Address 37 W. Preston Date signed 11-9-43

G 09875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09875
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address 1214 S. Chase St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Charles Rolle

3 (b) If veteran, name war

Spanish-American

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Maria E. Rolle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1873

8. AGE: Years Months Days If less than one day

69112423

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

Tinner

11. Industry or business

FATHER
MOTHER12. Name Melchor Rolle13. Birthplace Germany14. Maiden Name Metildia Kretchner15. Birthplace Germany

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 7 1943

(b)

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1214 S. Chase St

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-1943 at M

21. I certify that I took charge of the remains described above, held an

inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at M

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally, M.D.

Medical Examiner.

Date signed Nov 6, 1943Thomas J. McKeown, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

44376 09876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09876

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

HARRY PYLANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

Beatrice

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

6-9-10

8. AGE:

Years

Months

Days

If less than one day

33

4

27

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

CAB DRIVER

11. Industry or business

12. Name

HARRY PYLANT

13. Birthplace

Md.

14. Maiden Name

MAMIE CANNON

15. Birthplace

Md.

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof Nov 9 1943

(c) Cemetery or crematory

Oak Lawn Cem.

Location

Rural

18 (a) Funeral director

William H. Williams

(b) Address

204 S. Orleans St.

NOV 7 - 1943

(Date rec'd by registrar)

William H. Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

BALTIMORE

(If outside city or town limits, write RURAL and give town)

(d) Street No.

151 N. Decker Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 6

1943, at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1943 to Nov 6 1943, and that I last saw him alive on Nov 6 1943.

Immediate cause of death

cinchona of liver

Due to chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. Williams

Address

J H H

Date signed

11-6-43

G 09877

BALTIMORE CITY HEALTH DEPARTMENT

G 09877

CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address ~~4362~~ 33rd & Calvert
 (c) Hospital or institution: Union Memorial Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
 (e) Length of stay in Baltimore (yrs., mos., or days) 12 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 4362 Shamrock
 (If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3 (a) FULL NAME

Mary Elizabeth Kelley

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

No

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 23, 1943

8. AGE: Years Months Days If less than one day

0

0

13

hr.

min.

9. Birthplace

Baltimore, Md

(Town, county, and state)

10. Usual Occupation

Infant

11. Industry or business

12. Name

Paul Kelley

13. Birthplace

U.S. Army, Baltimore

14. Maiden Name

Anna E. Dietrich

15. Birthplace

Baltimore

16. Address

Hospital

17 (a) (b) Date thereof

(Burial, cremation, or removal)

(Month) (day) (year)

(c) Cemetery or crematory

Baltimore City

Location

18 (a) Funeral director

Ulrich Funeral Home

(b) Address

2014 E. Orleans St

(c) Address

4444

(d) Address

4444

VS 124

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/43 19 at 9:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/43 19, and that I last saw her alive on 11/5/43 19.

Immediate cause of death

Atelectasis

Due to

respiratory failure

atelectasis

Due to

Other Conditions

Fractures of humerus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

at autopsy

22. If death was due to external causes, fill in the following

a. Location, nature, or force

Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Hugh H. Powers Jr

Address Union Memorial Hospital Date signed 11/6/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 09878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09878
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days) **7-5**

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **4-17-42**

8. AGE: Years Months Days If less than one day

1 **6** **19** hr. min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) **Burial**

(b) Date thereof **Nov. 8, 1943**

(c) Cemetery or crematory **Asbury, b. em.**

Location **Baltimore, Calvert Co., Md.**

18 (a) Funeral director **B. Hanawalt & Danavan**

(b) Address **86 N. 12 Chestnut Ave.**

19 (a) **NOV 7 - 1943**

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County **Calvert**

(c) City or town **Rural - St Leonard**

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) **Yes**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 6 1943 at 5:10 PM**

21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 4 1943** to **Nov. 6 1943** and that I last saw him alive on **Nov. 6 1943**.

Immediate cause of death

Cardiac Failure

Due to **Exhaustion + Dehydration + Acidosis**
Due to **Diarrhea + Obitr. med.**

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **C. Lee Randol**

Address **Johns Hopkins Hosp.**

Address **Johns Hopkins Hosp.**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Huntington Williams, M.D.

370

G 09879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH00879
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **md.** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give name)(d) Street No. **16 N. Washington St.**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Viola Monroe

3 (b) If veteran, name war

V

3 (c) Social Security Account

No. **V**

4. Sex

Female5. Color or race **White**

6 (a) Single, married, widowed, or divorced

Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6-21-06

8. AGE: Years Months Days If less than one day

37**4****14**

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

home duties

11. Industry or business

12. Name **Hubbin Bryant**13. Birthplace **Virginia**14. Maiden Name **Myrtle Fitzgerald**15. Birthplace **Virginia**16 (a) Informant **Records**(b) Address **JOHNS HOPKINS HOSPITAL**17 (a) **Burial** (b) Date thereof **Nov 8/43**
(Burial, cremation, or removal) (month, day, year)(c) Cemetery or crematory **Mount Olivet Cem.**Location **Frederick Ave.**18 (a) Funeral director **John A. Mitchell**(b) Address **1900 Eutaw Place**(c) Date of registration **Nov 7 - 1943** (b) **Huntington Williams**

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 5 1943 at 2 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 16 1943** to **Nov 5 1943**, and that I last saw him live on **Nov 5 1943**.Immediate cause of death **circulatory failure** DurationDue to **peritonitis**Due to **ulcers of buttocks**Other Conditions **gangrene of both legs**
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: **gangrene of leg & buttocks, exclusion of vessels**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature **Ed. Longmire Jr.**Address **Johns Hopkins Hosp.** Date signed **11/6/43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

6309850

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937
Registered No. 6309850

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 3413 Fairview Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME

Emma L. Garton

3 (b) If veteran, name was

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1856

8. AGE: Years 87 Months 8 Days - 1 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Mr William C. Garton

13. Birthplace R.J.

14. Maiden Name Ellen Rimby

15. Birthplace Baltimore, Md.

16 (a) Informant Margaret G. Perry

(b) Address 3413 Fairview Ave.

17 (a) Burial (b) Date thereof 11/8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 - 1943
(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1943 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Nov 5 1943, and that I last saw her alive on Nov 4 1943.

Immediate cause of death Autonephrotic Crisis secondary to Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. S. Blum

Address 3513 Bowdoin Ave.

Date signed 11/6/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09881

Registered No.

937

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Caton Avenue*

(c) Hospital or institution:

St. Agnes Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) / *none*(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *2218 Booth Street*

(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs Mary Douglas

3 (b) If veteran, name war

3 (c) Social Security Account

No

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

*Widowed*6 (b) Name of husband or wife *George W. Douglas*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 28, 1871*

8. AGE:

Years

Months

Days

Less than one day

*72**5**9*

hr.

min.

9. Birthplace *Baltimore, Maryland*

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

*None*12. Name *George Beerschnidt*13. Birthplace *Germany*14. Maiden Name *Marquetta Marshing*15. Birthplace *Germany*16 (a) Informant *Mrs. Luke Duffy*(b) Address *3428 Frederick Avenue*17 (a) *Basal* (b) Date thereof *11-9-43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Two Cathedra*Location *Baltimore, Maryland*18 (a) Funeral director *George W. Schwal*(b) Address *2101 Frederick Ave.*(c) *Huntington Williams, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *11-6* 19*43*, at *3*^{*45*} *A* M21. I certify that death occurred on the date above stated; that I attended deceased from *9-19* 19*43*, to *11-6* 19*43*, and that I last saw her alive on *11-6* 19*43*.

Immediate cause of death

*Cerebral hemorrhage*Due to *Hypertension C-V*
sinus

Due to

Other Conditions *none*

(Include pregnancy within 3 months of death)

Date of operation *none*

Major findings of operations

of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? *2*

(Specify type of place)

(e) Means of injury

23. Signature *Howard H. Stier*Address *St Agnes Hospital* Date signed *1/16-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09882

BALTIMORE CITY HEALTH DEPARTMENT

G 09882

Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town, give RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or other)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 6, 1943, 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4, 1943, to Nov. 6, 1943, and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death

Congestive Heart Failure

Due to

Hypertensive C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address St. Joseph's Hosp. Date signed 11-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly stated. Physicians: please write the causes of death clearly and legibly.

NOV 7 1943

Huntington Williams, M.D.

G 09883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09883

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address **3623 Gibbons Ave.**
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) **6 years**

3 (a) FULL NAME

Rose Marie Smoot

3 (b) If veteran, name war

3 (c) Social Security Account No. **056-05-2016**4. Sex
Female5. Color or race
white6 (a) Single, married, widowed, or divorced.
Married6 (b) Name of husband or wife **Vernon A.**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Aug. 10 1904**8. AGE: Years **39** Months **2** Days **28** hr. **27** min.9. Birthplace **New York City**
(Town, county, and state)

10. Usual Occupation

11. Industry or business **Glenn Martin Co.**12. Name **Francisco Muccia**13. Birthplace **Naples Italy**14. Maiden Name **Maria Pietro Pinto**15. Birthplace **Naples**16 (a) Informant **Mr. Paul Smoot**(b) Address **321 Winston Ave**17 (a) **Burial** (b) Date thereof **11/9/43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **Calvary Cemetery**
Location **Brooklyn N.Y.**18 (a) Funeral director **William J. Tickner & Sons**(b) Address **North & Pennsylvania Ave.**(c) **Funeral home** **William J. Tickner & Sons**
Address **North & Pennsylvania Ave.**(d) **Funeral home** **William J. Tickner & Sons**
Address **North & Pennsylvania Ave.**(e) **Funeral home** **William J. Tickner & Sons**
Address **North & Pennsylvania Ave.**

2. USUAL RESIDENCE OF DECEASED:

(a) **Md.** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **3623 Gibbons Ave**
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

Rose Marie Smoot

MEDICAL CERTIFICATION

20. DATE OF DEATH **November 7 1943** at **1:00 P.M.**21. I certify that death occurred on the date above stated; that I attended deceased from **Sept 1943**, to **Nov. 7 1943**, and that I last saw him alive on **Nov 6 1943**.

Immediate cause of death

Carcinoma of BreastDuration
18 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **April 1941**Major findings of operations **Carcinoma of Breast**
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
 (b) Date of occurrence at M
 (c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature **Francis V. Gluck** M.D.Address **715 Park Ave** Date signed **11/7/43**

Gluck

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

NOV 7 - 1943

VS 138

G 09884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *937*

G 09884

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *3027 Raynor Ave*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *16*(e) Length of stay in Baltimore (yrs., mos., or days) *22 yrs*

3 (a) FULL NAME

Jennie C Lamb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

*W*6 (a) Single, married, widowed, or divorced. *Widowed*6 (b) Name of husband or wife *Wm T Lamb*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 12 - 1969*8. AGE: Years Months Days *74 54 1922* hr. min.9. Birthplace *Washington D.C.*

(Town, county, and state)

10. Usual Occupation *Retired*11. Industry or business *Same*12. Name *Thomas Bartlett*13. Birthplace *Conn*14. Maiden Name *Unknown*

15. Birthplace

16 (a) Informant *Elizabeth W Andersen*(b) Address *3027 Raynor Ave*17 (a) *Burial* (b) Date thereof *Nov 9 - 43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Westbury*

Location

18 (a) Funeral director *Charles P Towell*(b) Address *3027 Raynor Ave*

NOV 7 - 1943

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *md* (b) County(c) City or town *Baltimore md*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3027 Raynor Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 6 - 1943* at *4:40 PM*21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 13 1943* to *Nov 5 1943* and that I last saw her alive on *Nov 5 1943*Immediate cause of death *My peritumour arteriosclerotic type cordis vascul for discase*Due to *generalized arteriosclerosis*

Due to

Other Conditions *Chronic Bronchitis bronchial asthma*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

*W. Michel*Address *2901 Edmondson*Date signed *Nov 7, 43*

M. D.

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(b) Street address 1348 Cleveland St

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1348 Cleveland St
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

3 (b) If veteran, name war 3 (c) Social Security Account
No. 704

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1943, at 9³⁰ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1943 to Nov. 3 1943 and that I last saw her alive on Nov. 3 1943.

Immediate cause of death

Due to Hypernatremia Cardiac
Renal Disease

Other Conditions *Febrile of interest*

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) *Antisocial, suicidal, or homicidal*

(b) Date of occurrence

(c) *Where did injury occur?*

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(v) Means of injury

23. Signature

Address

Address 426 11th Ave Date signed 10/6/43

4. Sex F	5. Color or race C	6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lawrence Allen		6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 5, 1894		
8. AGE: Years 48	Months 8	Days 28 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name _____

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Lawrence J. Allery
(b) Address 1248 West 10th St

17 (a) Bureau (b) Date thereof 20.7.88
(Bureau, information, or removal) all all all all all

(c) Cemetery or crematory Mt Calvary C
Location _____

18 (a) Funeral director Thomas J. R. Williams

(b) Address 322 N Schwanitz St

19 (a) Huntington Williams, M.R.

(Date rec'd by institution)

OV 215 1943

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. **Phrysians:** please write the causes of death clearly and legibly.

G 09886

Ransom

BALTIMORE CITY HEALTH DEPARTMENT

G 09886

Registered No.

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 953 Md. Ave

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)(d) Street No. 953 Md. Ave
(If not give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Ransom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Nelson Ransom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1891

8. AGE: Years 51 Months 11 Days 19 hr. min.

9. Birthplace Calverton, Md
(Town, county, state)

10. Usual Occupation Domestic

11. Industry or business

12. Name of father Homer Ransom

13. Birthplace Calverton, Md

14. Maiden Name of mother Burlingame Ransom

15. Birthplace Calverton, Md

16 (a) Information Mrs. Mary Davis

(b) Address 953 Md. Ave

17 (a) Burial (b) Date thereof Nov. 23, 1943

(c) Cemetery or crematory Calverton, Md

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 N. Schroeder St

19 (a) Date of death Nov. 7, 1943 (b) Time of death 11:45 AM

20. DATE OF DEATH 11/4/43 11:45 AM

21. I certify that death occurred on the date above stated; that I attended the deceased from 11/3 to 11/4/43 and that I last saw him alive on 11/4/43

Immediate cause of death carcinoma of breast

Due to John Hopkinson Ransom

Due to long time

Other condition: This patient had been operated on for cancer of the breast in 1938

Major findings of autopsy: carcinoma of breast

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. C. Ransom M. D.

Address 322 N. Schroeder St

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/43 11:45 AM

21. I certify that death occurred on the date above stated; that I attended the deceased from 11/3 to 11/4/43 and that I last saw him alive on 11/4/43

Immediate cause of death carcinoma of breast

Due to John Hopkinson Ransom

Due to long time

Other condition: This patient had been operated on for cancer of the breast in 1938

Major findings of autopsy: carcinoma of breast

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. C. Ransom M. D.

Address 322 N. Schroeder St

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09887
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1520 E. Baeto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
65 hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address 1520 E. Baeto St

17 (a) Burial, cremation, or removal

(b) Date thereof Nov. 7-43
(month) (day) (year)(c) Cemetery or crematory
Location

18 (a) Funeral director

(b) Address 1520 E. Baeto St

19 (a) Date rec'd by registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baeto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1520 E. Baeto St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6-43 1943 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1942, to Nov 6, 1943, and that I last saw him alive on 19

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Daniel Wolfe

Address 1331 North Ave Date signed 11-7-43

Duration

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09888

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 629 St. Anne Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs

3 (a) FULL NAME

Phillip R. Weissman

3 (b) If veteran, name was

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Emma Weissman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1860

8. AGE:

Years

Months

Days

If less than one day

83--

hr.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual Occupation

Shoemaker

11. Industry or business

Straw Hats

FATHER

12. Name

John Weissman

MOTHER

13. Birthplace

Germany

14. Maiden Name

Gertrude Duval

15. Birthplace

Germany

16 (a) Informant

Mrs. G. Duval Cleary

(b) Address

610 Gaitman Ave

17 (a)

Burial

(b) Date thereof

Nov 8 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Parkwood Cemetery

Location

18 (a) Funeral director

Max M. Wiedefeld

(b) Address

501 E. 53rd St

19 (a) Date of registration

Nov 2 - 1943

(Date rec'd by registrar)

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

629 St. Anne Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 5 - 1943

21. I certify that death occurred on the date above stated; that I attended

deceased from Oct 1 1943 to Nov 5 1943and that I last saw him alive on Nov 4 1943Immediate cause of death ShockMyocarditisDue to Injurylacerations wound onDue to headOther Conditions Age 1 &Heart trouble

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident(b) Date of occurrence Nov. 3 at 8 P M(c) Where did injury occur? Home 629 St. Anne

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? Home While at work? yes

(Specify type of place)

(e) Means of injury Fell down23. Signature Edw. J. WilliamsAddress 9858 N. ...Date signed 9/43

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Duration

96 hrs10 hrs36 hrs

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Attorney by Howard J. Williams, M.D.

G 09889

M2 84653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09889

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 530 N. Charles St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Solomon Weeks

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-09-1415

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife Maude (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1885

8. AGE:

Years

Months

Days

If less than one day

58

2

19 20

hr.

min.

9. Birthplace South Carolina

(Town, county, and state)

10. Usual Occupation

Fireman

11. Industry or business

FATHER

12. Name

Goeffrey

13. Birthplace

South Carolina

MOTHER

14. Maiden Name

Hester Lamon

15. Birthplace

South Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address

(RECORDS)

17 (a)

Burial

(b) Date thereof

11 8 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Mt. Auburn Cem
Baltimore Md

18 (a) Funeral director

(b) Address

William A Jackson
916 Pennington

19 (a)

1943

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/4

1943 at 11:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1943 to 11/4 1943.

and that I last saw him alive on 11/4 1943.

Immediate cause of death

Acute cardiac failure

Duration

2 d.

Due to

Lytic C.V. disease

Due to

Decomp. & asphyxia in-sufficiency

1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

E. L. Sargman

Address

BCH

Date signed 11/5

G 09890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09890

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 2025 St. Fayette Street
- (c) Hospital or institution: Bow Secours Hospital
- (d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 days
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) Ind. (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 2809 Woodbrook Ave
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Baby Boy Lehr (Twins B)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced 2

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-4-43

8. AGE: Years Months Days If less than one day
1 7 2 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Harry Henry Lehr
13. Birthplace Baltimore, Md.
14. Maiden Name Anne Pauline Pope
15. Birthplace Columbia, D.C.

- 16 (a) Informant Anne Pauline Lehr
- (b) Address 2809 Woodbrook Avenue

- 17 (a) Burial (b) Date thereof Nov 7-43
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory St. Peter's
Location Balto Md

- 18 (a) Funeral director George A. Farley
- (b) Address Fulton & Fayette

- NOV 7 - 1943 (b) Huntington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1943 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1943 to 11/5 1943 and that I last saw him alive on 11/5 1943

Immediate cause of death

Congenital atelectasisDue to Prematurity

Due to

Other Conditions

(Include pregnancy within 1 month of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel R. Jones

Address 2809 Woodbrook Ave Date signed 11/5/43

Duration

28 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G 09891
09891

MJ-78541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G 09891
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. 10 mos. 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country No. (Yes or No)
If yes, name country

3 (a) FULL NAME

John Stanton

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
Colored

6 (a) Single, married, widowed, or
divorced. Married, Widowed

6 (b) Name of husband or wife Gertrude (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1870

8. AGE: Years 72 Months 11 Days 21 If less than one day
hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

12. Name Robert Stanton

13. Birthplace Maryland

14. Maiden Name Josephine ?

15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Nov. 7, 1943
(Burial, cremation, or removal)

(c) Cemetery or crematory Arbutus Mem. Ch.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Ed. A. Ballard

(b) Address 1631 David Hill Ave.

19 (a) Nov 8 - 1943 (b) Thimbleton Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1943 at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1942 to 11-2 1943.
and that I last saw him alive on 11-2 1943.

Immediate cause of death

Due to Bronchopneumonia etc

Due to Inter-ventricular Conduction System Disease

Other Conditions Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald B. Hill

Address Baltimore City, Md. Date signed 11-8-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09892

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland(c) Hospital or institution:
South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)(d) Street No. 327 Macon Street
(If Rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes name country3 (a) FULL NAME JOHN. H. WILLIAMS

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. 190-03-9372

4. Sex

Male

5. Color or race

White6 (a) Single married, widowed, or divorced.6 (b) Name of husband or wife Sophia L. Williams6 (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) Oct 13-1894

8. AGE: Years Months Days If less than one day

49 48 110 22 - hr. - min.9. Birthplace Clearfield Co. Pa.
(Town, county, and state)10. Usual Occupation Foreman11. Industry or business Bethlehem, Fairfield Yard12. Name William Williams13. Birthplace unknown14. Maiden Name unknown15. Birthplace unknown16 (a) Informant Sophia L. Williams(b) Address 7402 School Ave. Dundalk Md.17 (a) Burial (b) Date thereof 11/8/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Oaklawn
Location Easton Ave. Balt. Md.18 (a) Funeral director Frank H. Newell(b) Address Pikesville, Maryland
Huntington Williams, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1943 at 6:50 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. L. Williams M.D.Date signed 11-5-43 as Medical Examiner.NOV 8 - 1943
(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09893
Registered No. 116304

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Leaton & Wilkens*

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. *3718 Frederick Ave*

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Louis Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

male

white

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) *Feb 5 - 1864*

8. AGE: Years Months Days If less than one day

79

9

1

— hr. *—* min.

9. Birthplace *Baltimore, Maryland*

Town, county, and state

10. Usual Occupation *Blacksmith*

11. Industry or business *Retired*

12. Name *August Hartman*

13. Birthplace *Germany*

14. Maiden Name *Lena O'Sullivan*

15. Birthplace *Germany*

16 (a) Informant *Harry Hartman*

(b) Address *6821 Rristerton Rd*

17 (a) *Burial* (b) Date thereof *11/8/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *London Park*

Location *Fredrick Road, Balto.*

18 (a) Funeral director *Frank H. Jewell*

(b) Address *Pikeville, Maryland*

(c) Date registered *Nov 8 - 1943*

(d) Registrar *Huntington Williams, M.D.*

(e) Address *St. Agnes Hospital*

(f) Date signed *11-6-43*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 6 - 1943* *12:20 A.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *11-4* 1942, to *11-6* 1943, and that I last saw him alive on *11-6* 1943.

Immediate cause of death

central hemorrhage

Due to *hypertension and*

injury

Due to

Other Conditions *none*

(Include pregnancy within 3 months of death)

Date of operation *none*

Major findings of operations

of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Howard W. Jones*

Address *St. Agnes Hospital*

Date signed *11-6-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09894
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Cecil

(c) City or town Rising Sun

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

May Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color of race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Morris Lucas

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

9-22-19

8. AGE:

Years

Months

Days

If less than one day

24

1

15

hr.

min.

9. Birthplace

New Jersey

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Margaret Steenland

13. Birthplace

Holland

14. Maiden Name

Jeanette Kiekland

15. Birthplace

Holland

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date there

Nov 10 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Brookview

Location

Rising Sun Md.

18 (a) Funeral director

E. J. Tyson

(b) Address

Rising Sun Md.

NOV 8 - 1943

(Date rec'd by registrar)

William Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 7

1943

at 7 AM

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Oct 26 1943 to Nov 7 1943

and that I last saw him alive on Nov 7 1943.

Immediate cause of death

Broncho pneumonia

Duration

Due to

Lupus erythematosus
disseminatus

?

Due to

Other Conditions

Pregnancy - 3 months
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. S. Cross Jr.

Address J. H. H.

Date signed 11-7-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09895

JL - 04651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09895

Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Md (b) County: Balt.
(c) City or town: 2115 Kirk Ave
(If outside city or town limits, write RURAL and give town)
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME

Otto Ottenbacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 20, 1888

8. AGE:

Years

Months

Days

If less than one day

54

11

16

hr.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual Occupation

Paperhanger

11. Industry or business

Self

FATHER
MOTHER

12. Name

Louis Ottenbacher

13. Birthplace

Germany

14. Maiden Name

Anna Kierman

15. Birthplace

Germany

16 (a) Informant

B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a)

Burial

(b) Date thereof

11/9/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Balto.

Location

Md.

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St.

NOV 8 - 1943

Huntington Williams M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1943, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1943, to Nov. 6, 1943, and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death Carcinoma of lungs & metastases

Duration
??

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Don J. Gumpert

M. D.

Address Balto City Hosp

Date signed Nov 12/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ *Geneste G* 09896
Registered No. 137a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *14 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *65 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) *State Md* (b) County

City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *407 Burton Place* *Baltimore*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Jessie Geneste

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. *NO RE*

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Mrs. Catherine Geneste*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *May 24 1878*

8. AGE: Years Months Days If less than one day

65

5

13

hr.

min.

9. Birthplace *Maryland*

(Town, county, and state)

10. Usual Occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name *Jessie Geneste*

13. Birthplace *Jessie*

14. Maiden Name *Emma Decker*

15. Birthplace *Germany*

16 (a) Informant *Mrs. Catherine Geneste*

(b) Address *407 Burton Place* *City*

17 (a) *Burial* (b) Date thereof *11/10/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Cathedral*

Location *Balto. Md.*

18 (a) Funeral director *William Cook Inc*

(b) Address *1217 St. Paul St*

NOV 8 - 1943 *Huntington Williams, M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 5 1943* *5:55 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 23 1943* to *Nov 5 1943*, and that I last saw him alive on *Nov 5 1943*.

Immediate cause of death

Duration

Benign prostatic hyperplasia
Due to *Benign prostatic hyperplasia*
Due to

2 weeks
15 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature *Isabella Harrison*

M. D.

Address *Church Home & Hospital* Date signed *11-5-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09897**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

8. AGE: Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

MOTHER: FATHER:

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

FREDERICK H. HERRMAN

09898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09898

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6312 Brook Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Balto
(If outside city or town limits, write RURAL and give town)(d) Street No. 6312 Brook Ave
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Addie Ewing

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or

Widowed

6 (b) Name of husband or wife

Charles Ewing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

Nov 8 - 1943

(Burial, cremation, or other)

(c) Cemetery or crematory

Woodlawn

Location

18 (a) Funeral director

(b) Address

NOV 8 - 1943

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1943, at M21. I certify that death occurred on the date above stated; that I attended deceased from October 1943 to Nov 4 1943, and that I last saw him alive on 11/3 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature

Address 532 E. 22nd St Date signed 11/5/43

Duration

1 mo

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

09899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09899
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution:

Barnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2809 Woodbrook Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Infant Lehr (Twin A.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-4-43

8. AGE: Years

Months

Days

If less than one day

3

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Mary Henry Lehr

13. Birthplace Baltimore, Md.

14. Maiden Name Laura Pauline Pope

15. Birthplace Columbia, South Carolina

16 (a) Informant HOSPITAL RECORD

(b) Address 2025 W. FAYETTE ST.

17 (a) BURIAL (b) Date thereof 11 8 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory ST. PETERS

Location BALTO. MD.

18 (a) Funeral director GEORGE A. FARLEY

(b) Address FULTON & FAYETTE ST.

19 NOV 8 - 1943 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-43 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-43 to 11-7-43 and that I last saw him alive on 11-7-43.

Immediate cause of death

Congestive heart failure
and pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis H. H. M. D.

Address Barnes Hospital Date signed 11-7-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09900

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Market.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA C. DAVIS

3 (b) If veteran, name war none 3 (c) Social Security Account No. none

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife DAVID F. DAVIS
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 6/12/1886

8. AGE: Years 56 Months 4 Days 26 If less than one day
hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation HW.

11. Industry or business

12. Name Conrad Beckley

13. Birthplace Md.

14. Maiden Name Koontz

15. Birthplace Md.

16 (a) Informant M. F. Davis

(b) Address Frederick - Md.

17 (a) Burial (b) Date thereof 11-10-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Johns Cem.

Location Frederick Md.

18 (a) Funeral director C. E. Clive & Son

(b) Address Frederick Md.

NOV 8 - 1943 Huntington Williams

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 19 43 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1943 to Nov 7, 1943 and that I last saw her alive on 11/7 19 43.

Immediate cause of death

Resp. Failure

Due to Cachexia

Due to Carcinoma of Bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury DPH

23. Signature DPH

Address Mercy Hosp. Date signed 11/10/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09901

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Balchum & Fayette St*

(c) Hospital or institution

Franklin Square Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *8 da*(e) Length of stay in Baltimore (yrs., mos., or days) *58 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*(d) Street No. *2038 W. Lawrence St*

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Frank Schulein

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 2-12-09-6544

4. Sex

Male White

5. Color or race

6 (a) Single, married, widowed, or divorced

*Married*6 (b) Name of husband or wife *Catherine Schulein*6 (c) If alive, give age *66* years7. Birth date of deceased (mo., day, yr.) *Nov 21, 1876*8. AGE: Years *66* Months *67* Days *11* If less than one day*17 1/2* hr. min.

9. Birthplace

*Germany*10. Usual Occupation *Shipping Clerk*11. Industry or business *American Sugar Refinery*12. Name *Unknown*13. Birthplace *Unknown*14. Maiden Name *Unknown*15. Birthplace *Unknown*16 (a) Informant *Filbert L. Schulein*(b) Address *8. Hillside Road*17 (a) *Burial* (b) Date thereof *Nov 10, 1943*(c) Cemetery or crematory *Woodlawn*Location *Md*18 (a) Funeral director *Mrs. John W. Tengel & Son*(b) Address *801 W. Fayette St*(c) *Huntington Williams*

MEDICAL CERTIFICATION

20. DATE OF DEATH *11-7-1943* at *7* AM21. I certify that death occurred on the date above stated; that I attended deceased from *10-30-1943* to *11-7-1943*and that I last saw him alive on *11-7-1943*

Immediate cause of death

Carcinoma of sigmoid colon

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

as above

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place)

While at work?

(e) Means of injury *Spontaneous*23. Signature *J. E. Keck* M. D.Address *2 E. Red St* Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3525 Dennison Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

3 (a) FULL NAME

Annette Morrow

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 212-07-9990

4. Sex

Female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1908

8. AGE: Years Months Days If less than one day

35 0 12 hr. min.

9. Birthplace

N. J.
(Town, county, and state)

10. Usual Occupation stenographer

11. Industry or business auto

12. Name Archie E. Morrow

13. Birthplace Ohio

14. Maiden Name Georgia Ellen Morgan

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Nelson Lee

(b) Address 3525 Dennison Road

17 (a) Burial (b) Date thereof Nov. 9, 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Md.

18 (a) Funeral director Mrs. John W. Tinsley & Son

(b) Address 801 W. Fayette St

19 (a) Date of death Nov 8, 1943 (b) Registrar

Huntington Williams, M.D.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3525 Dennison Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6, 1943, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1942 to 11/6 1943, and that I last saw him alive on 11/6 1943.

Immediate cause of death

Acute Cardiac Failure

Due to Rheumatic Cardiac Vasculitis

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph B. Lauriaty, M.D.

179 Washington Blvd Date signed 11/8/43

NOV 8 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09903

Registered No.

937

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address <u>709 Lennox Street</u> (c) Hospital or institution: <u>at home</u> (d) Length of stay in hospital or inst. (yrs., mos., or days) <u>XXXXXX</u> (e) Length of stay in Baltimore (yrs., mos., or days) <u>abt 45 Years</u>		2. USUAL RESIDENCE OF DECEASED: (a) State <u>Maryland</u> (b) County <u>Baltimore City</u> (c) City or town <u>Baltimore City</u> (If outside city or town limits, write RURAL and give town) (d) Street No. <u>709 Lennox Street</u> (If rural give location) (e) Citizen of foreign country? <u>NO</u> (Yes or No) If yes, name country <u>NO</u>	
3 (a) FULL NAME <u>MARGARET ELLA CUTHELL</u>			
3 (b) If veteran, name war <u>NONE</u>		3 (c) Social Security Account No. <u>NONE</u>	
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>Widow</u>	
6 (b) Name of husband or wife <u>Thomas H. Cuthell</u> 6 (c) If alive, give age <u>XXX</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Dec. 10, 1854</u>			
8. AGE: Years <u>88</u>	Months <u>10</u>	Days <u>24</u>	If less than one day hr. <u> </u> min. <u> </u>
9. Birthplace <u>Philadelphia, Pennsylvania</u> (Town, county, and state)			
10. Usual Occupation <u>NONE</u>			
11. Industry or business <u>NONE</u>			
FATHER	12. Name <u>Joseph K. Milnor</u>		
	13. Birthplace <u>UNKNOWN</u>		
MOTHER	14. Maiden Name <u>Margaret Ann Hoff</u>		
	15. Birthplace <u>UNKNOWN</u>		
16 (a) Informant <u>Miss Edith M. Franklin (daughter)</u> (b) Address <u>709 Lennox Street, Balto., Md.</u>			
17 (a) Burial <u>Burial</u> (b) Date thereof <u>Nov. -8-1943</u> (Burial, cremation, or removal) (month) (day) (year) (c) Cemetery or crematory <u>Loudon Park Cemetery</u> Location <u>Baltimore, Md.</u>			
18 (a) Funeral director <u>Stewart & Mowen Company</u> (b) Address <u>108 W. North Av. (W.F. Wooden-Suc.)</u>			
19 <u>NOV 8 - 1943</u> <u>Huntington Williams, M.D.</u>			
20. MEDICAL CERTIFICATION 20. DATE OF DEATH <u>11/4/43</u> 19 <u>43</u> at <u>11 PM</u> 21. I certify that death occurred on the date above stated; that I attended deceased from <u>July 1942</u> to <u>11/4 1943</u> , and that I last saw her alive on <u>11/4 1943</u> . Immediate cause of death <u>Cerebral Hemorrhage</u> Due to <u>Arterio-sclerosis</u> Due to <u>Hypertension</u> Other Conditions <u> </u> (Include pregnancy within 3 months of death) Date of operation <u> </u> Major findings of operations <u> </u> of autopsy <u> </u> 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence <u> </u> at <u> </u> M (c) Where did injury occur? <u> </u> (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? <u> </u> While at work? <u> </u> (Specify type of place) (e) Means of injury <u> </u> 23. Signature <u>W. H. Ready</u> Address <u>1403 Park Ave</u> Date signed <u>11/5/43</u>			

99904

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09904
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State of Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 413 S. Newberry St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

3 (c) Social Security Account
No. 220-20-5080

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1927

8. AGE: Years 16 Months 1 Days 1
If less than one day hr. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Worked at Hosp. after school

11. Industry or business Johns Hopkins Hospital

12. Name John J. Esser

13. Birthplace South Dicks

14. Maiden Name May Mullen

15. Birthplace West Va.

16 (a) Informant John J. Esser

(b) Address 413 S. Newberry St

17 (a) Burial (b) Date thereof 11-10-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Hearts

Location German Hill Road

18 (a) Funeral director Lilly & Zeller, Inc.

(b) Address 403 S. Wolfe St.

NOV 8 1943 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1943 at 10 P.M.

21. I certify that I took charge of the remains described above, held an
Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Compound
fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury Nov. 6, 1943 at 9:20 P.M.

(b) Where did injury occur? Holabird & Vantage Aves.

(c) Did injury occur at home, on farm, industrial place, in public
place? street While at work? no

(d) Means of injury struck by auto

23. Signature Robert L. Graham M.D.

Date signed Nov. 7 1943

09905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

G 09905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Baltimore City, Maryland
 (b) Street address: Wyman Park Drive and 31st St.,
 (c) Hospital or institution: US Marine Hospital, Baltimore, Md.
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos 13 da
 (e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Baltimore
 (c) City or town: Baltimore
 (d) Street No.: 806 South Curley Street
 (e) Citizen of foreign country? (If yes, name country) (Yes or No)

3 (a) FULL NAME PAUL ODEN

3 (b) If veteran, name war: None
 3 (c) Social Security Account No. NONE

4. Sex: Male
 5. Color or race: White
 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
 6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1875
 8. AGE: Years 68 Months 9 Days 5 If less than one day hr. min.

9. Birthplace: Stockholm, Sweden
 (Town, county, and state)

10. Usual Occupation: Retired-LHS Service

11. Industry or business: Seafaring

12. Name: Unknown

13. Birthplace: Sweden

14. Maiden Name: Selma Oden

15. Birthplace: Sweden

16 (a) Informant: Records-US Marine Hospital
 (b) Address: Baltimore, Maryland.

17 (a) BURIAL (b) Date thereof NOV. 8/43
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: ST. MATTHEW
 Location: O'DONNELL ST.

18 (a) Funeral director: Lilly and Zeiler / N.C.

(b) Address: 401 AS. HOLEY ST.
 (Date rec'd by registrar) (b) Registrar: Huntingdon Williams, M.D.
 NOV 8 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1943 at 9:20 AM

21. I certify that death occurred on the date above stated that I attended deceased from April 22 43 Nov. 5, 1943 and that I last saw him alive on Nov. 5, 1943

Immediate cause of the sigmoid colon with metastasis in the liver, lungs, and brain
 Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operations:

AS ABOVE
 of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature: [Signature]

Address: US Marine Hospital
 Baltimore, Maryland. Date signed: 11/8/43

Duration
 Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09906

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09906

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Usual

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 NOV 8 - 1943

(Date not to be registered)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.

Major findings of operations.

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09907
Registered No.

131a

PLACE OF DEATH:				2. USUAL RESIDENCE OF DECEASED:			
(a) Baltimore City, Maryland				(a) Maryland (b) County			
(b) Street address 4211 Raspe Ave.				(c) City or town Baltimore			
(c) Hospital or institution:				(If outside city or town limits, write RURAL and give town)			
(d) Length of stay in hospital or inst. (yrs., mos., or days)				(d) Street No. 4211 Raspe Ave.			
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown				(e) Citizen of foreign country? No. (Yes or No)			
3 (a) FULL NAME William E. Dawson				MEDICAL CERTIFICATION			
3 (b) If veteran, name war		3 (c) Social Security Account No. 216-07-3681		20. DATE OF DEATH Nov. 6 th 1943, 7:50 P.M.			
4. Sex Male	5. Color or race White	6 (a) Single, married, widowed, or divorced Married		21. I certify that death occurred on the date above stated, that I attended deceased from 11/21 1942 to 11/6 1943, and that I last saw him alive on 11/6 1943			
6 (b) Name of husband or wife Sallie E. Dawson				Immediate cause of death CHRONIC NEPHRITIS			
6 (c) If alive, give age years				Due to ARTERIOSCLEROSIS			
7. Birth date of deceased (mo., day, yr.) Dec. 10 th 1885				Due to ARTERIAL HYPERTENSION			
8. AGE: Years 57		Months 10	Days 26	Other Conditions CHRONIC MYOCARDITIS			
If less than one day hr. min.				HYPERTRYPHY OF PROSTATE			
9. Birthplace Virginia				Date of operation			
10. Usual Occupation Night Custodian				Major findings of operations			
11. Industry or business				of autopsy			
12. Name George Dawson				22. If death was due to external causes, fill in the following:			
13. Birthplace England				(a) Accident, suicide, or homicide			
14. Maiden Name Harriet Lansdale				(b) Date of occurrence at M			
15. Birthplace England				(c) Where did injury occur? (City or town) (County) (State)			
16 (a) Informant Mrs. Sallie E. Dawson				(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?			
(b) Address 4211 Raspe Ave.				(e) Means of injury			
17 (a) Burial (b) Date thereof Nov. 9 th 1943				23. Signature John W. Maclean			
(Burial, cremation, or removal) (month) (day) (year)				Address 634 Belair Rd. Date signed 11/7/43			
(c) Cemetery or crematorium Lorraine							
Location Belts, Co. Maryland							
18 (a) Funeral director Eastern Funeral Home							
(b) Address 7401 Belair Road							
NOV 8 - 1943							

908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G 09908

CERTIFICATE OF DEATH 94a

Reg. Dist. No.

1. PLACE OF DEATH:

County 3005 Clifton Ave.
 City or town Baltimore, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles W. Gold

3. (b) Social Security Number

212-05-5304

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Maxie Boettinger Gold6. (c) If alive, give age 48 years

7. Birth date of

deceased (mo., day, yr.)

Nov. 5th, 1887

8. AGE:

Years

Months

Days

If less than one day

55

11

29

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Moulder

11. Industry or business

Gas & Electric Co.

FATHER

12. Name

Gold

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Jackson

15. Birthplace

Baltimore, Md.

16. Informant

Mrs Marie Gold

Address

3005 Clifton Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/8/43

(month) (day) (year)

Cemetery or crematory

Lorraine

Location

Baltimore

18. Funeral director

Address

NOV 8 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3005 Clifton Ave.

(If rural, give LOCATION)

2. (c) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th,1943 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 13, 1943 to Nov. 4, 1943

and that I last saw him alive on

October 21, 1943

Immediate cause of death

DURATION

Coronary Thrombosis2 1/2 hrs.

Due to

Due to

Other conditions

A-V Leak

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Remond Zapp
3101 W. Baltimore

M. D. or other

Date signed 11/6/43

09909

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09909
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address 18 S. Pulaski St.
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) Md. (b) County
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 18 S. Pulaski St.
 (If rural give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country

3 (a) FULL NAME

FANNYE WENDESHEIM.

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White6 (a) Single, married, widowed, or
divorcedSingle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1886

8. AGE: Years Months Days If less than one day

5771213

hr.

min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual Occupation Saleslady.11. Industry or business Dept. Store.12. Name Henry Windesheim,13. Birthplace Germany.14. Maiden Name Julia Lehman,15. Birthplace Germany.16 (a) Informant Mrs. L. Aaron(b) Address 18 S. Pulaski St.17 (a) Burial (b) Date thereof 11, 8, 43.
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.18 (a) Funeral director David Somers & Son(b) Address 1902 Eutaw PlaceNOV 8 - 1943 (Date received by Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH NOV. 6th. 19 43. 10 15 M

21. I certify that death occurred on the date above stated; that I attended
 deceased from Nov 4 19 43 to Nov 6 19 43,
 and that I last saw him alive on Nov 6 19 43.

Immediate cause of death

Cerebral Thrombosis

Duration

1 day

Due to

Diabetes mellitus10 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Julius F. LehmanAddress 6 E. Biddle St. Date signed 11/7/43 M. D.

PHYSICIAN

Underline the
 cause to which
 death should be
 charged statisti-
 cally.

09910

100 N. million ave

BALTIMORE CITY HEALTH DEPARTMENT

G 09910

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 620 McKEWIN AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO. MD

(d) Street No. 620 McKEWIN AVE

(e) Citizen of foreign country? (If rural give location)

(f) If yes, name country (Yes or No)

3 (a) FULL NAME

PHILIP A. EHART

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-01-1154

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife AMANDA EHART

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.)

JULY 5-1886

8. AGE:

Years

57

Months

4

Days

2

If less than one day

hr.

min.

9. Birthplace

BALTO MD

(Town, county, and state)

10. Usual Occupation

CABINET MAKER

11. Industry or business

HUTZLER BROS

FATHER

12. Name

ANSELM EHART

13. Birthplace

BERMAN

MOTHER

14. Maiden Name

SOPHIA REIS

15. Birthplace

BALTO MI

16 (a) Informant

AMANDA EHART

(b) Address

620 McKEWIN AVE

17 (a)

BURIAL

(b) Date thereof

NOV-10-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

BALTIMORE CEM.

Location

BALTO MD

18 (a) Funeral director

Bernard C. Harber

(b) Address

121 E. NEEB ST

NOV 8 - 1943

(Date rec'd by registrar)

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 7 1943, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30, 1942, to 11/5/43, 1943, and that I last saw him alive on 19.

Immediate cause of death Carcinoma

Due to Carcinoma of Esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation at Johns Hopkins

Major findings of operation: metastatic carcinoma of esophagus with lymphatic invasion of adjacent structures

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. J. Lankford

Address 100 N. million

Date signed 11/8/43

Duration

4 m

P

PHYSICIAN

Underline the cause to which death should be charged statistically.

443905
09911BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09911

Registered No.

58c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: **JOHNS HOPKINS HOSPITAL**(d) Length of stay in hospital or inst. (yrs., mos., or days) **17**

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)(d) Street No. **548 W. Hoffman St**
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male Black

5. Color or race

6 (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1-28-39

8. AGE:

Years

Months

Days

If less than one day

4**9****7**

hr.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

BROTHER FATHER

12. Name

Reginald Dorsey

13. Birthplace

Maryland

14. Maiden Name

Millie Faires

15. Birthplace

North Carolina

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL17 (a) **Burial**
(Burial, cremation, or removal)(b) Date thereof **Nov. 10, 1943**
(month) (day) (year)

(c) Cemetery or crematory

Wt. Zion Cem

Location

18 (a) Funeral director

Mr. Katie P. Williams

(b) Address

11. S. ...NOV 8 - 1943
(Date rec'd by registrar)(b) **...**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Nov. 5 1943** at **...** M21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 2 1943** to **Nov. 5 1943**, and that I last saw him alive on **Nov. 5 1943**.

Immediate cause of death

Cardiac Failure

Due to

Rheumatic Myocarditis

Due to

Acute Rheumatic Fever

Other Conditions

Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at **M**

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

Signature

Stanley L. Blumenthal

M. D.

Address

Johns Hopkins Hospital

Date signed

11/5/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 09912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6 09912

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address Cold Spring Nursing Home
(c) Hospital or institution:
2101 Cold Spring Lane
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Maderia St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Paul Schramm

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex
Male

5. Color or race
White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charlotte Schramm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1864

8. AGE: Years 79 Months 6 Days 76
If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name Louis Schramm

13. Birthplace Germany

14. Maiden Name Anna Felke

15. Birthplace Germany

16 (a) Informant Mrs. Charlotte Schramm

(b) Address 624 McKewin Ave.

17 (a) Burial (b) Date thereof Nov. 8/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Philip H. Hays, Sons

(b) Address 2024 Orleans St.

19 (a) Date of death Nov 8 - 1943

MEDICAL CERTIFICATION

11.30

20. DATE OF DEATH Nov. 5/43 19 at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1943 to Nov 5 1943, and that I last saw him alive on Nov 2 1943.

Immediate cause of death

valvular heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. N. Putterman

Address 2324 Reisterstown Rd Date signed 11/6/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09913

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09913
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **5913 Burgess Ave.**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **Life**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md.** (b) County
(c) City or town **Baltimore Md.**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **5913 Burgess Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **John Ries Jr.**

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Married**

6 (b) Name of husband or wife **Josephine Ries**
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Feb. 11, 1871**

8. AGE: Years **71** Months **8** Days **25** If less than one day hr. min.

9. Birthplace **Baltimore Md.**
(Town, county, and state)

10. Usual Occupation **Retired**

11. Industry or business

12. Name **John Ries Sr.**

13. Birthplace **Germany**

14. Maiden Name **Mary Lambert**

15. Birthplace **Balto. Md.**

16 (a) Informant **Mrs. Josephine Ries**

(b) Address **5913 Burgess Ave.**

17 (a) **Cremation** (b) Date thereof **Nov. 9/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Greenmount Cem.**
Location **Balto. Md.**

18 (a) Funeral director **Philip H. Hargis Sons**
Address **2024 Orleans St.**

19 **NOV 8 - 1943**
(Date rec'd by registrar)

Huntington Williams
Registrar

MEDICAL CERTIFICATION

7 AM

20. DATE OF DEATH **NOV. 6, 1943** 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from **December 5, 1942** to **November 6, 1943**, and that I last saw him alive on **November 6, 1943**

Immediate cause of death

Myoperthigiv Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **Fred B. Ries**
Address **825 E. 41st St.** Date signed **11/6/43**

Duration

Unknown as to the duration prior to 11/5/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

09914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09914

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2011 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Hilda Krevitt Hudson

3 (b) If veteran, name war

3 (c) Social Security Account
No. 217-16-0603

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Frank Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1910

8. AGE:

Years

Months

Days

If less than one day

33

hr.

min.

9. Birthplace Australia

(Town, county, and state)

10. Usual Occupation

Waitress

11. Industry or business

FATHER
MOTHER

12. Name Dryden

13. Birthplace Australia

14. Maiden Name Unknown

15. Birthplace Australia

16 (a) Informant Mrs. Ann Baylin

(b) Address 519 N. Washington St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Nov. 11, 1943

(month) (day) (year)

(c) Cemetery or crematory Moreland Men. Park

Location Balto, Md.

18 (a) Funeral director

Philip Hurwig Sons

(b) Address

2024 Orleans St.

19 (a)

Date rec'd by registrar

NOV 8 - 1943

(b)

Huntington Williams, M.D.

23. Signature

Address 7007

Date signed 9/8/43

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1943 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Nov. 7, 1943, and that I last saw her alive on Nov. 7, 1943.

Immediate cause of death

Carcinoma of rectum with metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09915
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

hr. min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

09916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09916

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 16

3 (a) FULL NAME

Skirley KAISER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1941

8. AGE:

1

11

17

If less than one day

hr.

min.

9. Birthplace Pasadena

(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
MOTHER

12. Name Charles Kaiser

13. Birthplace Baltimore

14. Maiden Name Louise Strecker

15. Birthplace Baltimore

16 (a) Informant hospital records

(b) Address

17 (a) Burial (b) Date thereof Nov 9, 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory Glen Haven Pk

Location

18 (a) Funeral director A. J. Donald Evans

(b) Address 400 S Charles St

NOV 8 - 1943

Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town PASADENA
(If outside city or town limits, write RURAL and give town)(d) Street No. Boulevard Park
(If rural give location)(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1943 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1943 to 11-7 1943, and that I last saw her alive on 10-7 1943.

Immediate cause of death

Respiratory failure

Duration

Due to

meningitis

3 wks.

Due to

probably tuberculous

Other Conditions

prob military tbc
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Swille M. D.

Address Sydenham Hosp. Date signed 11-7-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09917
Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Genl Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1013 Patapsoo St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Carrie M.

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. 212-09-9543

4. Sex

F

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife Emanuel Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1886

8. AGE: Years Months Days If less than one day

57

0

16

hr.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Co.

11. Industry or business U. S. Printing & Lithographing

FATHER

12. Name Frederick Myers

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Annie Hinkel

15. Birthplace Balto., Md.

16 (a) Informant Mr. George F. Selby

(b) Address 1013 Patapsoo St.

17 (a) Burial (b) Date thereof 11/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

NOV 8 - 1943

VS 151

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1943, at 11:10 A.M.

21. I certify that I took charge of the remains described above, held an
Inspection & autopsy and from the evidence obtained
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came
to her death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☐ suicide ☒
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Lye

poisoning

Due to

Other Conditions

Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury Nov. 5, 1943 4:20 P.M.

(b) Where did injury occur? 1013 Patapsoo St.

(c) Did injury occur at home, on farm, industrial place, in public
place? home While at work? no

(d) Means of injury Swallowed Lye

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Nov. 7 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09918

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County aa Co
(c) City or town North Linthicum
(If outside city or town limits, write RURAL and give town)
76 Annapolis Rd.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

JOHN EBERT

3 (b) If veteran, name war

none

3 (c) Social Security Account

No. none

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widower

6 (b) Name of husband or wife

Christina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

2/22/1872

8. AGE:

Years 71

Months 8

Days 14

If less than one day

hr.

min.

9. Birthplace Cincinnati, Ohio

(Town, county, and state)

10. Usual Occupation

Retired B. & O. Conductor

11. Industry or business

FATHER

12. Name

John Ebert

13. Birthplace

Germany

MOTHER

14. Maiden Name

Unknown

15. Birthplace

"

16 (a) Informant Mrs. Emma Young

(b) Address Linthicum Heights

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

11/9/43

(month) (day) (year)

(c) Cemetery or crematory

St. Paul's Immanuel

Location

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/6/

1943

M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30, 1939 to Nov 6, 1943 and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death

Hemiplegia
right side

Due to

Due to

Hemiplegia, a right side

Other Conditions

cardiac
hypertension, chronic

(Include pre-mortem conditions)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Edward Norris
Address 107 East West St. Date signed 11/8/43

Duration

Nov 4, 43

34 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 8 - 1943

09919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered 09919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1510 E. Pratt St.
(b) Street address:
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. Earnest Cole

3 (b) If veteran, name war 3 (c) Social Security Account No. 217-07-1726

4. Sex Male 5. Color or race Col. 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 55 Months Days If less than one day hr. min.

9. Birthplace Virginia Laborer (Town, county, and state)

10. Usual Occupation

11. Industry or business Unknown

12. Name

13. Birthplace

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mary Dyson
(b) Address 1510 E. Pratt St.

17 (a) Burial (b) Date thereof 11/8/43
(Burial, cremation, or removal) Mt. Calvary (month) (day) (year)

(c) Cemetery or crematory Elroy O. Wilson
1000 Brantley Ave.

18 (a) Funeral director

(b) Address

19 (c) NOV 8 - 1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-43 19 at 2:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31-1942 to 11-4-1943, and that I last saw him alive on 11-3-1943.

Immediate cause of death

Lobar Pneumonia

Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm H. Carroll

Address 611-h. Caroline Date signed 11-6-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Wm H. CARROLL

09920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09920

Registered No.

PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Baltimore, Md.**
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **422 E. Clement**
(If rural give location)
(e) Citizen of foreign country Yes or No
If yes, name country

3 (a) FULL NAME **MARCELLUS J. HOOK**3 (b) If veteran, name war
3 (c) Social Security Account
No. **213-10-8589**4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced **Single**6 (b) Name of husband or wife
6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr) **June 23, 1901**8. AGE: Years **42** Months **4** Days **15** If less than one day
hr. min9. Birthplace **Baltimore, Md.**
(Town, county, and state)10. Usual Occupation **Shipbuilder**11. Industry or business **Bethlehem Steel**FATHER 12. Name **John N. Hook**13. Birthplace **Balto., Md.**MOTHER 14. Maiden Name **Josephine Landers**15. Birthplace **Richmond, Va.**16 (a) Informant **Mrs. Marie Allen**
(b) Address **422 E. Clement St.**17 (a) **Burial** (b) Date thereof **11-11-43**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery **Cathedral**
Location **Baltimore Md.**18 (a) Funeral director **Thompson & Thompson**(b) Address **1426 High St.**19 (a) **NOV 8 - 1943** (b) **Huntington Williams, M.D.**

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH **November 9,** 19 **43**, at **5⁴⁵ AM**

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature **J. J. Wollanweber** M.D.Date signed **11-8-43** **Ant** Medical Examiner.

09921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09921

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOM

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2823 Brighton St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

WILLIAM

S.

KNIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Lola K. Knight

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.)

May 19 1908

8. AGE:

Years

Months

Days

If less than one day

35

5

18

hr.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual Occupation

Patrolman

11. Industry or business

Baltimore City

FATHER

12. Name

Jammie R. Knight

13. Birthplace

Washington D.C.

MOTHER

14. Maiden Name

Katie L. Snyder

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mrs. Lola K. Knight

(b) Address

2823 Brighton St

17 (a)

Burial

(b) Date thereof

11/11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

London Pk.

Location

Frederick Ave. Baltimore

18 (a) Funeral director

Robert S. Little

(b) Address

2700 Edmondson Ave.

NOV 8 - 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1943 at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐ accident ☐ suicide ☐homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Bullet wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-7-43 at 10:00 P.M.

(b) Where did injury occur? 1000 W. Rutland

(c) Did injury occur at home, on farm, industrial place, in public place? ☒ While at work?

(d) Means of injury Revolver - shot while

23. Signature W. Z. Wollenshagen M.D.

Date signed 11-8-43

pursuing autopsy

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09922

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

NOV 8 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

1943

21. I certify that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

G 09923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09923
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 20 N. East Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 20 N. East Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Katherine E. Duffy

3 (b) If veteran, name war

3 (c) Social Security Account

No. ---

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Owen T. Duffy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1896

8. AGE: Years

47

Months

5

Days

24

If less than one day

hr.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Wm. Dashner

13. Birthplace Balto. Md.

14. Maiden Name Elizabeth Anchutz

15. Birthplace Balto. Md.

16 (a) Informant Owen T. Duffy

(b) Address 20 N. East Ave.

17 (a) Burial (b) Date thereof Nov. 10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Balto. Md.

18 (a) Funeral director Philip Hewing Sons

(b) Address 2024 Orleans St.

19 (a)

(Date of registration)

NOV 8 - 1943

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 6/43 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1943 to 11-6 1943, and that I last saw him alive on 10-5 1943.

Immediate cause of death

Due to Diabetic Coma

Due to Diabetic Mellitus

Due to

Other Conditions Pernicious Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. Dew

Address 490 E. Mon. St. Date signed 11/8/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

124 G 09924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 497

G 09924
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Katie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-2-79

8. AGE:

Years

Months

Days

If less than one day

64

6

5

hr.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
MOTHER

12. Name

Charles Green

13. Birthplace

Maryland

14. Maiden Name

Elsie Hamilton

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof Nov 10 43

(Burial, cremation, or removal)

(c) Cemetery or crematory

St. Peter's Cem.

Location

18 (a) Funeral

Mrs. N. A. Elliott Daughter

(b) Address

1129 N. Caroline St.

NOV 8 - 1943

(b) Hunterdon Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1717 Maryland Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 7 1943 at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1943 to Nov 7 1943 and that I last saw him alive on Nov 7 1943.

Immediate cause of death

Uremia

? Pulmonary Embolism

Due to Femoral Thrombosis

Arteriosclerosis, general

Due to Hypertension

Other Conditions

Carcinoma of Vagina - post-operative.

(Include pregnancy within months of death)

Date of operation Nov 1, 1943

Major findings of operation: Carcinoma of Vagina - metastases to inguinal nodes of autopsy. Femoral Thrombosis

Duration

4 days

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Roger B. Scott

Address Johns Hopkins H. Date signed 11-9-43

G 09925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09925

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

St. Joseph's Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Mr. Richard D. Moffitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Anna D. Moffitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan - 16 - 1915

8. AGE:

Years

28

Months

9

Days

20

If less than one day

hr.

min.

9. Birthplace

W. Va.

(Town, county, and state)

10. Usual Occupation

Assembler

11. Industry or business

Eastern Aircraft

12. Name

Thomas E. Moffitt

13. Birthplace

Wash. Co. Pa.

14. Maiden Name

Mary D. Taylor

15. Birthplace

W. Va.

16 (a) Informant

Mrs. Anna D. Moffitt

(b) Address

217 Poplar Rd.

17 (a)

Burial

(b) Date thereof

Nov. - 43

(c) Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Rd.

18 (a) Funeral director

John P. Connolly

(b) Address

48 Eastern Ave.

19 (a)

Huntington Williams

(b)

Huntington Williams

20. DATE OF DEATH

November 6, 1943, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from Nov. 3, 1943, to Nov. 6, 1943,

and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death

Chronic Glomerulonephritis

Due to

Due to

Other Conditions

Same

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Major findings of operation:

of autopsy:

Same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(e) Means of injury

23. Signature

William H. Lusting

Address

St. Joseph's Hosp.

Date signed

11-6-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 8 - 1943

09926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09926
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3739 Woodbrook ave(e) Citizen of foreign country? No (If rural give location)

(Yes or No)

If yes, name country

3 (a) FULL NAME

S arantoo Sotero V loyantes

3 (b) If veteran, name war

1st World War

3 (c) Social Security Account

No. 122-01-2157

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-25-1881

8. AGE:

Years

Months

Days

If less than one day

56

2

109

hr.

min.

9. Birthplace

Bneee

(Town, county, and state)

10. Usual Occupation

Restaurant Business

11. Industry or business

12. Name

Soteros V loyantes

13. Birthplace

Bneee

14. Maiden Name

Degea

15. Birthplace

Bneee

16 (a) Informant

Soteros V loyantes

(b) Address

110 E. Montgomery

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

10-9-43

(month) (day) (year)

(c) Cemetery or crematory

Woodlawn Cem.

Location

Baltimore, Md

18 (a) Funeral director

Wm. J. Carrington

(b) Address

11 W. 25th St.

(Date rec'd by registrar)

NOV 8 - 1943

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-1943 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Homer J. Waldeis

M.D.

Date signed 11-5-43

Medical Examiner.

09927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09927
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State and (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1940 to Nov 2 1943.

and that I last saw her alive on Nov 2nd 1943.

Immediate cause of death

Cardiac degeneration
Pulmonary
Due to
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address 118 Bismarck St Date signed 11/8/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09928

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2311 CEDLEY

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTO CITY
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2311 CEDLEY ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN B KOTMAIR

3 (b) If veteran, name war

3 (c) Social Security Account
No. —

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife MAZIE KOTMAIR

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) NOV 9 1884

8. AGE: Years 58 Months 11 Days 26
If less than one day hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation RESTAURANT

11. Industry or business SELF

12. Name LOUIS P KOTMAIR

13. Birthplace BALTO MD

14. Maiden Name RACAEAL CREAMER

15. Birthplace BALTO MD

16 (a) Informant MAZIE KOTMAIR

(b) Address 2311 CEDLEY ST.

17 (a) Burial (b) Date thereof NOV 9 43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A. A. Co.

18 (a) Funeral director Bernard O. Harty

(b) Address 1211 E. 7th St.

(c) Huntington Williams, Md.

(d) 1943 (Date) (year) (month) (day) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 5 1943 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1943 to NOV 5 1943 and that I last saw him alive on NOV 5 1943.

Immediate cause of death

Cornmeal Intoxication

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Paul Schupfer M.D.

Address 2301 Campbell Date signed 8/13

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

09929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09929
Registered No.

PLACE OF DEATH:

Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

(c) If foreign born, how long in U. S. A?

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. Age

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 9 - 1943

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 6, 1943, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31, 1943, to Nov. 6, 1943, and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 514 Drury Lane Date signed 11/8/43

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

09930 STATE OF MARYLAND—CERTIFICATE OF DEATH

G 09930

1. PLACE OF DEATH

County Licking's Private HomeVillage or City Baltimore

Registration Dist. No.

No. 6 and Chapel Gate Lane

Ward

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME George B. M. Gibbs

If U. S. Veteran, specify WAR

(a) Residence: No. 6 and Chapel Gate Lane St.Ward. 2307If nonresident give city or town and State Del

PERSONAL AND STATISTICAL PARTICULARS

SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) marriedIf married, widowed, or divorced
HUSBAND of
(or) WIFE of Name of Wife unknownDATE OF BIRTH (month, day, and year) April 17, 1864AGE Years 79 Months 6 Days 22 If LESS than 1 day, 0 hrs. 0 min.8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Teacher9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. School10. Date deceased last worked at this occupation (month and year) June 1932 11. Total time (years) spent in this occupation 47BIRTHPLACE (city or town) Stewartstown
(State or country) Penn.13. NAME Peter Gibbs14. BIRTHPLACE (city or town) Stewartstown
(State or country) Penn.15. MAIDEN NAME Unknown16. BIRTHPLACE (city or town) Unknown
(State or country)INFORMANT Edgar Gibbs
(Address) Stewartstown, Penn.BURIAL, CREMATION, OR REMOVAL
Place Stewartstown Date Nov 12, 1943UNDERTAKER Dr. Howard Kraft
(Address) Green Grove York Co PaFILED 19 Huntington Williams

NOV 9 - 1943

If more blanks are needed, address State Registrar, 241 N. Charles Street, Baltimore, Requesting "U. S. No. 1."

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

November 8 1943
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from October 24, 1943 to November 5, 1943I last saw deceased alive on November 5, 1943; death is said to have occurred on the date stated above, at 31 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage
Myocardial InsufficiencyDate of onset 10/24/4310/26

Other Contributory Causes of importance:

Name of operation Clinical Date of 11/8/43
What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? 0 Date of injury 19Where did injury occur? 0 (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury 0Nature of injury 0

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Wilson K. Gaffney M. D.
(Signed) Catoonsville, Md.
(Address)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09931

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 mos

(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 9 1943

VS 114

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 7

1943

at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24/43 to 11-7-43

and that I last saw him alive on Nov 7 1943

Immediate cause of death

Hypertensive Heart Disease

Duration

Due to

Due to

Other Conditions

Congestive Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address

Date signed

11/7/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09932

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Calvert & Lantana St*

(c) Hospital or institution:

Mary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) *50 days*

(e) Length of stay in Baltimore (yrs., mos., or days) *5 yrs.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *5408 Monelle Rd.*
(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Calvin E. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife *Ethel Mitchell*

6 (c) If alive, give age *37* years

7. Birth date of deceased (mo., day, yr.) *March 9, 1893*

8. AGE: Years *50* Months *8* Days *27*
If less than one day hr. min.

9. Birthplace *Baltimore, Maryland*
(Town, county, and state)

10. Usual Occupation *Chief Clerk*

11. Industry or business *Term R.R.*

12. Name *Edward E. Mitchell*

13. Birthplace *Baltimore, Md.*

14. Maiden Name *Bessie Smith*

15. Birthplace *Baltimore, Md.*

16 (a) Informant *Record*

(b) Address *Mary Hosp.*

17 (a) *Buried* (b) Date thereof *11-9-43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Catharine*
Location *Baltimore*

18 (a) Funeral director *Leonard H. Smith*

(b) Address *5201 Highland Rd.*

NOV 9 1943 *Huntington Williams, M.D.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 6, 1943, at 5 P.M.*

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct 18, 1943, to Nov 6, 1943.* and that I last saw him alive on *Nov 6, 1943.*

Immediate cause of death *Cardiac failure*

Due to *Ischemic heart disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Edward E. Mitchell*

Address *Mary Hospital* Date signed *11/6/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09933

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4515 Harford Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4515 Harford Road
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 23 - 1854

8. AGE: Years Months Days

89

6

13

hr.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

John H. Schubert

13. Birthplace

Germany

14. Maiden Name

Mary

15. Birthplace

Germany

16 (a) Informant

Mrs. Mary Schubert

(b) Address

4515 Harford Rd

17 (a)

Burial

(b) Date thereof Nov 9, 43
(month) (day) (year)

(c) Cemetery or crematory

moreland

Location

Burkville

18 (a) Funeral director

Leonard J. Ruck

(b) Address

5305 Harford Road

19 (a)

Huntington Williams, M.D.

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1943, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1942 to Nov. 1943, and that I last saw him alive on 10-30-1943.

Immediate cause of death

Broncho Pneumonia

Duration

3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

II. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. W. Peake

Address 4508 Harford Rd

M. D. Date signed 11-8-43

NOV 9 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09934
Registered No.

1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address 1738 N Bond St (c) Hospital or institution: (d) Length of stay in hospital or inst. (yrs., mos., or days) (e) Length of stay in Baltimore (yrs., mos., or days)		2. USUAL RESIDENCE OF DECEASED: (a) State (b) County (c) City or town Baltimore (If outside city or town limit, write RURAL, and give town) (d) Street No. 1738 N Bond St (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country	
3 (a) FULL NAME John E Salter			
3 (b) If veteran, name war		3 (c) Social Security Account No.	
4. Sex Male	5. Color or race White	6 (a) Single, married, widowed, or divorced. Married	
6 (b) Name of husband or wife Eliza		6 (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) Jan 9. 1858			
8. AGE: Years 85 Months 9 Days 28 If less than one day hr. min.			
9. Birthplace Baltimore Md (Town, county, and state)			
10. Usual Occupation Retired Foreman			
11. Industry or business			
MOTHER	12. Name Theodore Salter		
	13. Birthplace Pa		
FATHER	14. Maiden Name Harriett Purley		
	15. Birthplace Md		
16 (a) Informant Adelaide Price			
(b) Address 1738 N Bond St			
17 (a) Burial, cremation, or removal Burial			
(b) Date thereof 11/10/43 (month, day) (year)			
(c) Cemetery or cremation Green Mount			
Location Baltimore Md			
18 (a) Funeral director William L. Jones			
(b) Address 1217 N. York St Huntington, Williams, Mrs			
19. Date of death Nov 7 1943			
20. DATE OF DEATH Nov 7 1943. 2:30 A M			
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1943, to Nov 7, 1943, and that I last saw him alive on Nov 6, 1943.			
Immediate cause of death Paralysis or Hemiplegia Left			
Due to Ruptured vessel in Brain			
Due to			
Other Conditions			
(Include pregnancy within 3 months of death)			
Date of operation			
Major findings of operation:			
of autopsy:			
22. If death was due to external causes, fill in the following:			
(a) Accident, suicide, or homicide			
(b) Date of occurrence at M			
(c) Where did injury occur? (City or town) (County) (State)			
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)			
(e) Means of injury Hemorrhage Cerebral			
23. Signature J. O. Cannon M. D.			
Address 1701 N. Caroline Date signed			

NOV 9 1943

VS 144

NOV 8 1943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 99935

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4617 Manasota Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

John T. Angland

3 (b) If veteran, name war

3 (c) Social Security Account

No. 214-01-9374

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Male

White

Married

6 (b) Name of husband or wife

Mary Angland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

April 15 - 1886

8. AGE: Years

Months

Days

If less than one day

57

6

22

hr.

min.

9. Birthplace

Ireland

10. Usual Occupation

Chauffeur

11. Industry or business

Globe Brewery

12. Name

Unknown Angland

13. Birthplace

Ireland

14. Maiden Name

15. Birthplace

16 (a) Informant

Mary V. Angland

(b) Address

4617 Manasota Ave

17 (a)

(Burial, cremation, or entombment)

(b) Date thereof

11/10/43

(c) Cemetery

St. Paul's

New Cathedral

Location

Balto Md

18 (a) Funeral director

William Cook Inc

(b) Address

1217 St. Paul St

(c) Date registered

11/10/43

Registrar

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 7

1943, 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to Nov 7 1943, and that I last saw him alive on Nov 4 1943.

Immediate cause of death

Carcinoma Stomach

Duration

8 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

J. S. Harding

Address 4810 Belair Rd

Date signed 11/8/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

467

Registered No. 09936

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 334 Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (year, month, or days) 22/5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MR. ABRAHAM ROUBEX

3 (b) If veteran, name war

?

3 (c) Social Security Account

No. ?

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Mrs. Sarah Rankey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1889

8. AGE: Years 54 Months 6 Days 6 hr. min.

9. Birthplace England

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

12. Name Sarah Rankey

13. Birthplace Russia

14. Maiden Name Leah Siskin

15. Birthplace Russia

16 (a) Informant Mrs. Sarah Rankey

(b) Address 3820 Barrington Rd. City.

17 (a) Burial (b) Date thereof 11-9-43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Southern Ave

Location Southern Ave

18 (a) Funeral director J. L. Lewis

(b) Address 1439 E. Belts St

19 NOV 9 - 1943

Huntington Williams M.D.

Address Union Mem. Hosp

Date signed 11/8/43

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 8 1943, at 1:07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1943, to Nov. 8 1943, and that I last saw him alive on Nov. 8 1943.

Immediate cause of death

Cardiac Resp. failure

Due to Carcinoma of Rectum

Due to Prostatic Enlargement

Other Conditions Septicemia

(Include pregnancy within 3 months of death)

Date of operation Oct. 26, 1943

Major findings of operation: Carcinoma of Rectum

of autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. L. Lewis

Address Union Mem. Hosp

Date signed 11/8/43

Duration

1 yr. approx

8 days

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

09937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09937
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1829 N. Collington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. 40-5-16
(yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)(d) Street No. 1829 N. Collington Avenue
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Mildred E. Amrhein

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife Bernard J. Amrhein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1903

8. AGE:

Years 40

Months 5

Days 16

If less than one day

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name John A. Frebert

13. Birthplace Baltimore, Md.

14. Maiden Name Mary A. Foy

15. Birthplace Baltimore, Md.

16 (a) Informant Bernard J. Amrhein

(b) Address 5632 Belair Road

17 (a) Burial (b) Date thereof 11-11-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oaklawn Cemetery

Location Eastern Avenue

18 (a) Funeral director Albert L. Hitt

(b) Address 1606 N. Chester Street

(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-43 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from May 11, 1942 to May 11, 1943

and that I last saw him alive on May 11, 1943

Immediate cause of death

Due to Rheumatoid Arthritis

Due to Acute Cardiac
Dilatation

Other Condition

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Fred R. Hitt, M.D.
Date signed 11-9-43

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

09938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09938
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1818 E. Oliver Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57-0-12

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)(d) Street No. 1818 E. Oliver Street
(If rural give location)

(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Nina M. Hoppert

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or
divorced.

Female

White

Married

6 (b) Name of husband or wife C. Elmer Hoppert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-181886

8. AGE: Years Months Days If less than one day
57 0 12 hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Joseph McComb

13. Birthplace Baltimore, Md

14. Maiden Name Mary Lamb

15. Birthplace Baltimore, Md,

16 (a) Informant Mr. C.E. Hoppert

(b) Address 1818 E. Oliver Street

17 (a) Burial (b) Date thereof 11-10-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Baltimore Cemetery
Location E. North Ave & Rose St

18 (a) Funeral director Albert L. Hitt

(b) Address 1806 N. Chester Street

NOV 9 - 1943 (b) Hunting for Williams MR

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1943, at 12:15 P. M.

21. I certify that death occurred on the date above stated; that I attended
deceased from Oct 16 1943, to Nov 6 1943,
and that I last saw her alive on Oct 16 1943.

Immediate cause of death.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public
place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address 1818 E 3 St Date signed 11/7/43

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statisti-
cally.

30 to appeared.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. **G 09939**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **1514 Division St.**
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **13**
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **2237 Madison Ave.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

William Oliver Wilson

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **June 12, 1881**

8. AGE: Years Months Days If less than one day
62 4 24 hr. min.

9. Birthplace **Maryland**

(Town, county, and state)

10. Usual Occupation **Chiropodist**

11. Industry or business

FATHER 12. Name **John D. Wilson**

13. Birthplace **Md.**

MOTHER 14. Maiden Name **Martha Handy**

15. Birthplace **Md**

16 (a) Informant **Mrs Laura Robinson**

(b) Address **725 N. Carey St.**

17 (a) **Burial** (b) Date thereof **11-10-43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Arbutus Mem. Park**
Location **Baltimore, Co., Md.**

18 (a) Funeral director **Mrs Frances A. Hemsley**

(b) Address **578 W. Biddle St.**

NOV 9 - 1943 **Washington Williams, M.D.**
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **NOV. 6, '43** 19 **at 7 P.M.**

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 5, 1943**, to **Nov 6, 1943**, and that I last saw him alive on **Nov. 6, 1943**.

Immediate cause of death

Cerebral Embolism
Due to **Bacterial Endocarditis**

Due to

Other Conditions

Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature **William H. Higgins**
Address **2243 Madison** Date signed **11/9/43**

Duration

10 days
1 month

PHYSICIAN

Underline the cause to which death should be charged statistically.

09940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09940

Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Macy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. Southern Hotel
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country3 (a) FULL NAME MRS. ALPHA J. BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Arthur F. L. Briscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 - 19028. AGE: Years Months Days If less than one day
41 9 28 hr. min.9. Birthplace Norfolk, Virginia
(Town, county, and state)10. Usual Occupation Home Duties

11. Industry or business

12. Name George Boyden Gill13. Birthplace Petersburg, Va.14. Maiden Name Alice W. Wade15. Birthplace Lynchburg, Va.16 (a) Informant Stephen E. Shuman(b) Address 6707 York Road (Son)17 (a) Burial (b) Date thereof Nov 9 - 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Grundy Ridge Cemetery
Location Baltimore18 (a) Funeral director Manuel Lopez Lopez(b) Address 1600 W. North Ave19 NOV 9 - 1943
Death reported by Dr. Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1943, at 11:30 M21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Scald, 2nd, 3rd degree

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 11-7-43 at 9 a 4/1 M(b) Where did injury occur? Southern Hotel(c) Did injury occur at home, on farm, industrial place, in public place? publ While at work?(d) Means of injury scalded in bathtub23. Signature H. A. Wallenweber M.D.
Medical ExaminerDate signed 11-8-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09941

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: *Howard + Madison*

(c) Hospital or institution:

Maryland General Hosp.

(d) Length of stay in hospital or inst. (*yes*, or days) *28*

(e) Length of stay in Baltimore (*yes*, mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *MD.* (b) County:

(c) City or town: *Baltimore* 15
(If outside city or town limits, write RURAL and give town)

(d) Street No.: *3117 Woodland Ave.*

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country:

3 (a) FULL NAME

Charles F. Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Katherine

6 (c) If alive, give age *7* years

7. Birth date of deceased (mo., day, yr.) *Aug. 26, 1886*

8. AGE: Years *57* Months *2* Days *11* If less than one day
hr. min.

9. Birthplace *Baltimore*
(Town, county, and state)

10. Usual Occupation *President*

11. Industry or business *Turner Fink*

12. Name *Charles Fink*

13. Birthplace *MD.*

14. Maiden Name *Annah Menges*

15. Birthplace *Germany*

16 (a) Informant *Mrs. Katherine Fink*

(b) Address *3117 Woodland Ave.*

17 (a) *Burial* (b) Date thereof *11/10/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Baltimore Cem*
Location *Balto, Md.*

18 (a) Funeral director *Wm. J. Lickner & Sons*

(b) Address *Balto Md.*

19 *NOV 9 1943* *Huntington Williams, M.D.*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 7* 19 *43* at *8:45* A M

21. I certify that death occurred on the date above stated; that I attended deceased from *Oct. 14* 19 *43* to *Nov. 7* 19 *43* and that I last saw him alive on *Nov. 7* 19 *43*.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *C. Herman Williams* M. D.

Address *Md. Gen. Hosp.* Date signed

Nov. 7, 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

099412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

099412

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address **819 Washington Blvd.**
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **819 Washington Blvd.**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

CATHERINE L. RICHARDSON

3 (b) If veteran, name war
none

3 (c) Social Security Account
No. **yes**

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced.
Married

6 (b) Name of husband or wife **William**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **Nov. 9, 1881**

8. AGE: Years Months Days If less than one day
61 11 28 hr. min.

9. Birthplace **Baltimore**
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name **William Michael Phleger**

13. Birthplace **Frederick, Md.**

MOTHER 14. Maiden Name **Louisa A. Hess**

15. Birthplace **Baltimore**

16 (a) Informant **Mrs. Mary Chambers**
(b) Address **819 Washington Blvd.**

17 (a) **Burial** (b) Date thereof **11/10/43**
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Loudon Park Cem.**
Location **Balto., Md.**

18 (a) Funeral director **WM. J. TICKNER & SONS**
(b) Address **Balto., Md.**

NOV 9 - 1943 (b) **Huntington Williams, M.D.**
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH **Nov. 7, 1943** at **1:55 M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Nov. 7, 1943** to **Nov. 7, 1943**, and that I last saw him alive on **Nov. 7, 1943**.

Immediate cause of death **Coronary Thrombosis** Duration **2 days.**

Due to **Generalized arteriosclerosis** **several**
arteriosclerotic heart disease **years.**
with hypertension

Other Conditions **Arterial Lumbago** **1 year**
hemiplegia
(Include pregnancy within 6 months of death) **PHYSICIAN**

Date of operation
Major findings of operations
of autopsy:
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at **M**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury
23. Signature **W. H. Nichol** M. D.
Address **2401 Edmondson** Date signed **Nov 9, 1943**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

09943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09943
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1601 N. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

ANNA CATHERINE SMITH

3 (b) If veteran, name war
None

3 (c) Social Security Account
No. None

4. Sex
Female

5. Color or race
White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1869

8. AGE: Years Months Days If less than one day
74 8 21 hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Peter Orlando Firor

13. Birthplace Frederick Co., Md.

MOTHER 14. Maiden Name Mary Catherine Ogle

15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. B. R. Taylor

(b) Address 1601 N. Hilton St.

17 (a) Burial (b) Date thereof 11/9/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 NOV 9 - 1943

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1943, at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1943 to 11/7 1943, and that I last saw her alive on 11/7 1943

Immediate cause of death Edema of lungs
Acute cardiac failure

Due to Senility

Due to

Other Conditions Ch. Bronchitis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Geo. E. Wells
Address 4100 Edmonson Ave Date signed 11/8/43
Authorized by chief med. inspector

Duration
2 hrs
4 hrs
1 hr

1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 G 09944
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1632 Ashland Av

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1632 Ashland Av

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Sarah GROSS (nee) Downs

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

John Downs

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1869

8. AGE:

Years

Months

Days

If less than one day

74

hr.

min.

9. Birthplace

Annapolis Md.

(Town, county, and state)

10. Usual Occupation

housewife

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Kimball

13. Birthplace

Annapolis Md

14. Maiden Name

Elizabeth Lee

15. Birthplace

Annapolis Md

16 (a) Informant

Thomas Taylor

(b) Address

1632 Ashland Av

17 (a)

Burial

(b) Date thereof

11 10 43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arboretum M. Park

Location

Arboretum Md

18 (a) Funeral director

Mrs Ida Bailey

(b) Address

1421 Jefferson St

Huntington Williams, Md

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

11.6

1943, 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1943 to 11.6 1943. and that I last saw him alive on 11.4 1943.

Immediate cause of death

Hypertensive
cardio-vascular
disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Address 1200 E. Madison St Date signed 11/10/43

Rayner Brown

NOV 9 1943

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09945
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution:

South Baltimore's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 822 N. Clinton St.

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (George HINES) GEORGE ALFRED HINES

3 (b) If veteran, name war
No

3 (c) Social Security Account
No None

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Matilda S. Hines

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) January 9, 1868

8. AGE: Years 75 Months 9 Days 30 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired mail carrier

11. Industry or business Post Office

12. Name John Henry Hines

13. Birthplace Germany

14. Maiden Name Mary Eliz. Battenfield

15. Birthplace Germany

16 (a) Informant Mrs. Edna M. Burkhardt

(b) Address 449 N. Clinton St.

17 (a) Burial (b) Date thereof 11/11/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address 1349 E. North Ave.

NOV 9 1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1943, at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1943 to Nov 8 1943, and that I last saw him alive on Nov 8 1943.

Immediate cause of death

Bronchopneumonia

Due to Cerebral hemorrhage

Due to Arteriosclerotic
cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles R. M. D.

Address 1213 Light St. Date signed 11-9-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓
G 09946
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2306 Fleet St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md

(b) County - -

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2306 Fleet St.
(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME

ADAM DEHRING

3 (b) If veteran, name war
NO

3 (c) Social Security Account
No. none

4. Sex
male

5. Color or race
white

6 (a) Single, married, widowed, or divorced
single

6 (b) Name of husband or wife - - -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28. 1893

8. AGE: Years Months Days If less than one day
59 11 9 8 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Own Business

12. Name Martin Dehring - deceased

13. Birthplace Germany

14. Maiden Name Mary Meyer - deceased

15. Birthplace Baltimore

16 (a) Informant Mr. Harry Dehring

(b) Address 3938 Edmondson Ave.

17 (a) Burial (b) Date thereof Nov. 9. 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address North Ave. & Broadway.

NOV 9 1943

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6. 1943 at 8.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22, 1943 to Nov. 6, 1943 and that I last saw him alive on Nov. 6, 1943.

Immediate cause of death

Uremia

Due to Strictures of Urethra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles S. Levy

Address 117 Medical Bldg Date signed 11/8/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09947

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09947

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

John Trogdon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Male Black

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-30-43

8. AGE:

Years

Months

Days

If less than one day

45

6

hr.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual Occupation

Chief

11. Industry or business

FATHER
MOTHER

12. Name

Arranger Trogdon

13. Birthplace

N. Carolina

14. Maiden Name

Mavis Gaskins

15. Birthplace

Virginia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a)

Burial

(b) Date thereof

Nov. 9, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Wt. Calvary

Location

Wt. Calvary

18 (a) Funeral director

Raymond Sanders

Address

1743 E. Preston St.

19 (a)

NOV 9 - 1943

(Date rec'd by registrar)

VS 184

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1316 N. Chapel St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 6

1943

at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from

Oct 24

1943

to Nov 6 1943

and that I last saw him alive on

Nov. 6 1943

Immediate cause of death

Asphyxiation

Due to

Dysentery (Flex)

Due to

Stitis media
Lumbago

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

C. E. Randol

Address John Hopkins Hospital signed 11/7/43

09948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09948
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

University Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) *D-0-A*

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1319 N. Bond Street*

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Wirt Morton

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

65

hr.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Nathan B. Morton

13. Birthplace

Va.

MOTHER

14. Maiden Name

Fattie Brown

15. Birthplace

Va.

16 (a) Informant

Dorothy Morton

(b) Address

1907 N. 10th St. Phila. Penn.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

10-9-43
(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

B. B. Co.

18 (a) Funeral director

Radner Sanders

(b) Address

*1712 E. Preston St.*NOV 9 - 1943
(Date rec'd by registrar)(b) *Huntington Hill, Md.*

MEDICAL CERTIFICATION

20. DATE OF DEATH *11-2-1943* *12:12 P.M.*

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardiac. No other disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury *at* *M.*

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? *While at work?*

(d) Means of injury

23. Signature *Howard J. Malleis* M.D.

Medical Examiner.

Date signed *11-3-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 09949

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write R.R. No. and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19

NOV 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/7 1943 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1943 to 11/7 1943.

and that I last saw her alive on 11/7 1943.

Immediate cause of death

Septicemic heart

shock, etc.

Due to

Senility, etc.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PHYSICIAN

Underline the cause to which death should be charged statistically.

09950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09950
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 3409 Walbrook Ave
(c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minerva F. Smigert

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married6 (b) Name of husband or wife Charles L. Smigert
6 (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Nov. 18, 18718. AGE: Years 71 Months 11 Days 21 If less than one day hr. min.9. Birthplace Newark N.J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business at home12. Name J. Moffett Reilly13. Birthplace Newark N.J.14. Maiden Name Mary M. Jarvis15. Birthplace Newark N.J.16 (a) Informant Charles L. Smigert(b) Address 3409 Walbrook Ave17 (a) Burial (b) Date thereof Nov 11, 1943
(burial, cremation, or removal) (month, day, year)(c) Cemetery or crematorium Wood Ridge
Location Pikesville Rd18 (a) Funeral director Harry R. Armstrong(b) Address 4204 Ridgewood Ave(a) Nov 9 1943 (b) Dr. Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-1943 at 6:14 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

- (a) Date of injury _____ at _____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work?
(d) Means of injury _____

23. Signature Thomas J. Maloney M.D.
Date signed 11-9-43 Medical Examiner.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09951
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence

Burke

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex M 5. Color or race C 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1913

8. AGE: Years 30 Months 8 Days 20 If less than one day hr. min.

9. Birthplace Columbia, S.C.
(Town, county, and state)

10. Usual Occupation Salvage

11. Industry or business

FATHER 12. Name John Burke

13. Birthplace South Carolina

MOTHER 14. Maiden Name Fannie Snapp

15. Birthplace South Carolina

16 (a) Informant Robert Moore

(b) Address 720 Wilmer Court

17 (a) Shipped (b) Date thereof 11-10-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Columbia, S.C.

18 (a) Funeral director William A. Jackson

(b) Address 266 Penna. Ave.

NOV 9 - 1943
(Date rec'd by registrar) Wm. A. Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1943 at 8¹⁰ P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Nov. 6 1943 7⁵⁵ P.M.

(b) Where did injury occur? Wilmer Alley, George St

(c) Did injury occur at home, on farm, industrial place, in public place? street While at work? no

(d) Means of injury stabbed

23. Signatures Robert Lee Graham M.D.

Date signed Nov 7 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09952

JL- 84285

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09952

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Talbott
3 (b) If veteran, name war 3 (c) Social Security Account No.
4. Sex F 5. Color or race C 6 (a) Single, married, widowed, or divorced? ?
6 (b) Name of husband or wife ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25th, 1883
8. AGE: Years Months Days If less than one day
60 0 10 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Frank Talbott
13. Birthplace Md.
MOTHER 14. Maiden Name Hannah Thompson
15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. S. Refson

(b) Address 1303 Presaimgu

NOV 9 - 1943
Date of death 11/9/43
Cause of death Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-1943, at 8:00 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 10-11-1943 to 11-5-1943, and that I last saw him alive on 11-5-1943.

Immediate cause of death

Due to Pulmonary Infarct
Due to Post Operative
Sanguine Pt. Hem
Due to Alcoholic Intoxication

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-6-43

Major findings of operation: Sanguine
Pt. Hem.
of autopsy: Alcoholic

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Donald B. Webb

Address Baltimore City Hosp. Date signed 11-6-43 M. D.

Duration

3 hrs

1 min

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

09953

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

- (d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex
Male5. Color or race
Colored6 (a) Single, married, widowed, or divorced.
Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15 1886

8. AGE: Years Months Days If less than one day
57 21 hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

12. Name John Howard

13. Birthplace Va.

14. Maiden Name Sally?

15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mt Calvary
Location a a to m d

18 (a) Funeral director L. Brown

(b) Address 108 W Montgomery St

NOV 9 1943 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1943 at 12:50 A

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1943 to 11/6 1943, and that I last saw him alive on 11/6 1943.

Immediate cause of death
Lobar pneumoniaDuration
2 wks

Due to

Due to

Other Conditions A.S. H.C.V.D.;
Toxic ileus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Serpman
Address B C H Date signed 11/6/43

PHYSICIAN
Underline the cause to which death should be charged statistically.

G 09954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09954
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

South Baltimore Gen'l Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pud. (b) County(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 525 S. Sharp St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account No. none

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1900

8. AGE: Years Months Days If less than one day

43

1

6

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Labor

11. Industry or business

FATHER
MOTHER12. Name Frederick Wengert

13. Birthplace

Germany

14. Maiden Name Katherine Blumhine

15. Birthplace

Germany

16 (a) Informant Mrs. Catherine Wentworth(b) Address 715 Ave Brooklyn Park Md17 (a) Burial (b) Date thereof 10/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cedar HillLocation Brooklyn Md18 (a) Funeral director William M. Mareck(b) Address 215 Light St19 NOV 9 1943 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1943, at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an

Disputation thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐homicide ☐ undetermined ☐ and that the causes of death wereIMMEDIATE CAUSE OF DEATH Chronic valvularheart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert B. Graham M.D.Date signed Nov. 7 1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09955

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09955
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 929 N. Washington St.
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 5 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Washington
(If rural give location)
(e) If foreign born, how long in U. S. A. years

3 (a) FULL NAME

Rosa Allia Weeks

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Charlie Bell Weeks6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

August 24, 1880

8. AGE:

Years 63 Months 2 Days 13 If less than one day
hr. min.9. Birthplace Nashville, North Carolina
(Town, county, and state)10. Usual Occupation Housewife11. Industry or business At Home12. Name Frank Taylor13. Birthplace Nashville, N.C.14. Maiden Name Vance15. Birthplace N.C.16 (a) Informant Mrs. Anna Abrenski(b) Address 929 N. Washington St., Balto., Md.17 (a) Removal (b) Date thereof Nov. 9, 1943
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Mutual Burial Home
Location At Rock Mount, N.C.18 (a) Funeral director A. Bailey Stude(b) Address 4907 York RoadNOV 9 - 1943 (b) Thurston Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1943, at 10³⁰ P.M.21. I certify that death occurred on the date above stated, that I attended deceased from October 27, 1943 to November 7, 1943, and that I last saw her alive on November 7, 1943.Immediate cause of death
Arterio-sclerotic myocardial
hypertensive diseaseDue to Lobar PneumoniaDue to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph DunderAddress 1701 E. Fayette Date signed 11/9/43

Duration

7 yrs
10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09956

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G 09956

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH: 2908 Oakhill ave

County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 yrs

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Md County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2908 Oakhill ave
(If rural, give LOCATION)

2.(e) If veteran, name war _____

3. (a) FULL NAME

Mabel Elsie Ireland

3. (b) Social Security Number _____

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

August Ireland

7. Birth date of deceased (mo., day, yr.)

June 1 18748. (c) If alive, give age 71 years

8. AGE:

Years

Months

Days

If less than one day

69587

hrs.

min.

9. Birthplace

Cumberland Allegany Co Md
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Wm R Elsie

13. Birthplace

MOTHER

14. Maiden name

Harriet A. Harper

15. Birthplace

Randolph Co W Va.

16. Informant

August Ireland

Address

2908 Oak Hill ave

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Nov 11-43
(month) (day) (year)

Cemetery or crematory

Rose Hill cem

Location

Cumberland Md

18. Funeral director

A Riley Seade

Address

4907 York Road

NOV 9 - 1943

Huntington Williams, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 8 1943 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 - 1938 to Nov 8 1943
and that I last saw him alive on Nov 7 - 1943

Immediate cause of death

Cerebral hemorrhage

Due to

arteriosclerosis -hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, outside, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Howard Garrison
M. D. or otherAddress 2607 Garrison StDate signed 11-9-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09957

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09957
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1400 - N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town 3801 GLENMOIRE
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

BABY BOY Mc QUEENEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
9 hr. min.

9. Birthplace BALTO
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name THOMAS Mc QUEENEY

13. Birthplace BALTO

14. Maiden Name HELEN BUTHE

15. Birthplace

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) REMOVAL (b) Date thereof 11-9-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington P.C.

18 (a) Funeral director James J. Jackson & Son

(b) Address North P. Pennsylvania

19 (a) Date of death 11-9-43 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 / 9 19 43 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 / 31 19 43 to 11 / 9 19 43, and that I last saw him alive on 11 / 9 19 43.

Immediate cause of death Infection
Dysentery

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. B. Ballina

Address St. Joseph's Hosp. Date signed M. D.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 9 1943

11/9/43

G 09958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09958

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1313 Emsor St.

(c) Hospital or institution:

At Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)(d) Street No. 1313 Emsor St.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Elizabeth S. Mickelly

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Joseph V. Mickelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 19, 1889

8. AGE:

Years

Months

Days

If less than one day

61 yrs319

hr.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

House Work at

11. Industry or business

HomeFATHER
MOTHER

12. Name

Michael Geisler

13. Birthplace

Baltimore, Md.

14. Maiden Name

Margaret Greenwald

15. Birthplace

Baltimore, Md.

16 (a) Informant

Mrs. Monaghan (Daughter)

(b) Address

1313 Emsor St.17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Nov. 12/43

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Cemetery

Location

4430 Belair Rd.

18 (a) Funeral director

James W. Conklin, Inc.

(b) Address

824 E. Eager St.

1999-1940

Thurston Williams, M.D.

(Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1943 at 11:30 PM21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Nov 8 1943 and that I last saw him alive on Nov 8 1943

Immediate cause of death

Cerebral hemorrhage

Due to

hypertension

Due to

Other Conditions

Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Thurston Williams

Address

3136 Kearsford RdDate signed 11/9/43

Duration

6 Days2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

cert age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09959
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *Quickens Ave. + Caton Ave.*

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *45 yrs.*

3 (a) FULL NAME

Myrtle Jew

3 (b) If veteran, name was

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Gustavus M. Jew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 7, 1882*

8. AGE: Years Months Days If less than one day

*61**5**-**hr.**min.*9. Birthplace *Ind.*

(Town, county, and state)

10. Usual Occupation *H.W.*

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address *3907 Edmondson Ave.*17 (a) *Burial*(b) Date thereof *Nov. 11/43*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Wood Ridge*Location *Pikesville, Ind.*18 (a) Funeral director *Harry H. Witzke*(b) Address *4101 Edmondson Ave.*19 (a) *1943*(b) *Washington, D.C.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Ind.*

(b) County

(c) City or town

Baltimore

(d) Street No.

3907 Edmondson Ave.

(e) Citizen of foreign country

(If rural give location)

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 7/43* 19 *43* at *10:30 P.M.*

21. I certify that death occurred on the date above stated; that I attend-

ed deceased from *11/3* 19 *43* to *11/7* 19 *43*.and that I last saw him alive on *11/7* 19 *43*

Immediate cause of death

*Cerebral hemorrhage*Due to *hypertension and arteriosclerosis*Due to *diarrhea*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place) While at work?

(e) Means of injury

23. Signature *Thos E. Roach*Address *3629 Edmondson Ave.* Date signed *11/8/43**Balto-29-43*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 9 1943

VS 150

ROACH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09960

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1308 Beason St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1308 Beason St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John G. Grimmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary M. Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1872

8. AGE: Years 71 Months 9 Days 5 If less than one day
hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

12. Name Peter Grimmer

13. Birthplace Germany

14. Maiden Name Barbara

15. Birthplace Germany

16 (a) Informant Mrs. Mary M. Grimmer

(b) Address 1308 Beason St.

17 (a) Burial (b) Date thereof Nov. 10, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Rd.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 E. Edmondson Ave.

(c) Date rec'd by Registrar Nov 9 - 1943

(d) Signature of Registrar Walter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1943 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1943 to 11/7 1943, and that I last saw him alive on 11/5 1943

Immediate cause of death Coronary sclerosis

Due to

Due to Acute myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury Myocardial infarction

23. Signature Dr. Peter S. Newcomb M. D.

Address 1016 S. East Ave. Date signed 11/8/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09961
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 6 S. East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Assunta Ciambuschini

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife late Vincenzo Ciambuschini

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1869

8. AGE: Years Months Days If less than one day

74

7

28

hr.

min.

9. Birthplace Pitigliano Italy

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

12. Name Pietro Pallini

13. Birthplace Italy

14. Maiden Name Rosina Fabriziani

15. Birthplace Italy

16 (a) Informant Reginald Ciambuschini (Son)

(b) Address 6 S. East Ave

17 (a) Burial (b) Date thereof Nov. 10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 E. Frederik Rd.

18 (a) Funeral director Frank Della Nore

(b) Address 52 N. Morley St.

NOV 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1943, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21, 1943, to Nov. 7, 1943, and that I last saw her alive on Nov. 7, 1943.

Immediate cause of death

Congestive Heart Failure

Duration

1 day

Due to Arteriosclerosis

Chronic Myocarditis

Unknown

Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Philip Artigiani

Address 2942 E. Fayette St. Date signed 11/8/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 09962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09962

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address *126 S. Carey St.*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *19*

(e) Length of stay in Baltimore (yrs., mos., or days) *Life*

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No. *none*

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife *Helen E. Tuttle*

6 (c) If alive, give age *5* years

7. Birth date of deceased (mo., day, yr.) *Sept 17, 1883*

8. AGE: Years *60* Months *1* Days *21* hr. *20* min.

9. Birthplace *Baltimore, Md.*
(Town, county, and state)

10. Usual Occupation *Laborer*

11. Industry or business

12. Name *Thomas Tuttle*

13. Birthplace *Ireland*

14. Maiden Name *Catherine Crow*

15. Birthplace *Ireland*

16 (a) Informant *Mrs Helen E. Tuttle*

(b) Address *126 S. Carey Street*

17 (a) *burial* (b) Date thereof *11/11/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *New Cathedral Cemetery*
Location *4300 Sep. Frederick Road*

18 (a) Funeral director *John Cowan & Son*

(b) Address *901 Hollins St.*

(c) Date of registration *Nov 9, 1943*

Registrar *Huntington Williams, M.D.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*

(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)

(d) Street No. *126 S. Carey St.*
(If rural give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 7, 1943* at *11:15* AM

21. I certify that death occurred on the date above stated; that I attended deceased from *May 7 1943* to *Nov 7 1943*, and that I last saw him alive on *Nov 6 1943*.

Immediate cause of death
Hypertension Cardiovascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence *Nov 7 1943* at *11:15* AM

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature *Albert Korman*

Address *1834 Wilkins Ave* Date signed *11/8/43*

Duration
2 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 9 1943

VS 154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09963

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5211 Old Frederick Rd. Cat Md.

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1943

8. AGE: Years Months Days If less than one day

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Thomas B. Martin

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Virginia E. Wilson

15. Birthplace Baltimore, Md.

16 (a) Informant Thomas B. Martin

(b) Address 5211 Old Frederick Road

17 (a) Burial (b) Date thereof Nov. 9, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director J. Howard Strong

(b) Address 4307 W. North Ave.

(a) 1943 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 / 19 / 1943, at 4:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/1943, to 11/8/1943, and that I last saw her alive on 11/8/1943.

Immediate cause of death Thrombosis

Duration

Due to Thrombosis

Due to Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles P. Conroy

Address Bon Secours Date signed 11/9/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09964

1937 G 09964

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(Date rec'd by registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09965

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09965

Registered No. _____

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address _____

(c) Hospital or institution: _____

(d) Length of stay in hospital or inst. (yrs., mos., or days) *20 day*

(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mda.* (b) County _____(c) City or town *Baltimore*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *1528 Park Ave.*

(If rural give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3 (a) FULL NAME

Mr. Wm. Anthony Clisham

3 (b) If veteran, name war _____

3 (c) Social Security Account

No. _____

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

*married*6 (b) Name of husband or wife *Rose H.*

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Jan. 7, 1901*

8. AGE: Years

Months

Days

If less than one day

*42**10**2*

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Radio - Music Store*11. Industry or business *Self*12. Name *Wm. J. Clisham*13. Birthplace *Md.*14. Maiden Name *Mary Ford*15. Birthplace *Md.*16 (a) Informant *Mr. Vincent L. Clisham*(b) Address *4120 Fernhill Ave.*17 (a) *Burial*(b) Date thereof *11/12/43*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *New Cathedral Cem.*

Location

*Baltov, Md.*18 (a) Funeral director *WM. J. TICKNER & SONS*(b) Address *Balto., Md.*19 (a) *NOV 9 - 1943*

(b)

VS :

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/9/43* 19 *43*, at *2* *15* *4* *M*21. I certify that death occurred on the date above stated; that I attended deceased from *10/24/43* 19 *43*, to *11/8/43* 19 *43*, and that I last saw him alive on *11/8/43* 19 *43*.Immediate cause of death *P.V. collapse*
Torpid

Duration

Due to *P.V. Accident*Due to *Hypertension + Atherosclerosis*Other Conditions *1. Dilated, Irregular*
2. Bilateral Thrombophlebitis
(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?

(Specify type of place)

(e) Means of injury _____

23. Signature *Charles F. Spring*Address *Bon Secours* Date signed *11/14/43*

PHYSICIAN

Underline the cause to which death should be charged statistically.

G-09966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2030 Druid Hill Avenue

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME

Baby James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1943

8. AGE: Years Months Days If less than one day
13 hr. 29 min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

12. Name Irvin James

13. Birthplace Maryland

14. Maiden Name Anna Jackson

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address Johns Hopkins Hospital

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School NOV 9 1943

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 9 - 1943 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 43 at 4:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 19 43 to Oct. 14 19 43, and that I last saw him alive on Oct. 14 19 43.

Immediate cause of death Prematurity

Duration

Due to Prolapse of cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

P. Williams

M. D.

Address Johns Hopkins Hospital Date signed 10-18-43

G 09967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09967
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: *Caton & Wilkins Ave*(c) Hospital or institution: *St Agnes Hospital*

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. *705-10-3114*

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife

*Manuel B.*6 (c) If alive, give age *70* years7. Birth date of deceased (mo., day, yr.) *July-26-1873*8. AGE: Years *70* Months *3* Days *12* hr. min.9. Birthplace *BALTIMORE, MARYLAND*
(town, county, and state)10. Usual Occupation *MOULDER*11. Industry or business *BTO. RAILROAD*12. Name *JERRY FOWLER*13. Birthplace *MD.*14. Maiden Name *MARGARET MORGAN*15. Birthplace *MD.*16 (a) Informant *MAMIE B. FOWLER*(b) Address *922 LEEDS AVENUE*17 (a) *BURIAL* (b) Date thereof *NOV, 10-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *LODON PARK*Location *FREDERICK AVENUE.*18 (a) Funeral director *C. RAYMOND KAUFMAN*(b) Address *1026 LEEDS AVENUE.*19 *NOV 9 - 1943* (b) *Huntington Williams, M.D.*

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County *Baltimore*(c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)(d) Street No. *922 Leeds Ave*
(If rural give location)(e) Citizen of foreign country (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/7* 19 *43* at *12-M*21. I certify that death occurred on the date above stated; that I attended deceased from *11/2* 19 *43* to *11/7* 19 *43* and that I last saw him alive on *11-7* 19 *43*.

Immediate cause of death

*Uremia*Due to *Cardio renal disease*

Due to

Other Conditions *diabetes mellitus*
(Include pregnancy within 3 months of death)Date of operation *none*

Major findings of operations

of autopsy: *none*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature *Howard W. Steer*Address *St Agnes Hosp.* Date signed *11-7-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

09968

HEALTH DEPARTMENT—CITY OF BALTIMORE

09968

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Dolphin St., 7 Ward)

Length of residence in city or town where death occurred 69 yrs. 17 mos. 17 How long in U. S. If of foreign birth? 17 yrs. 17 mos. 17 ds.

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mary Madden

(a) Residence: No. 528 Dolphin

(Usual place of abode)

St., 7 Ward

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race Col. 5. Single, Married, Widowed, or Divorced (write the word) wid.

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. Madden

6. DATE OF BIRTH (month, day, year) Jan 1-74

7. AGE Years 64 Months 10 Days 5 If LESS than 1 day, 5 hrs. or 5 min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Ind.

13. NAME Henry Harris

14. BIRTHPLACE (city or town) (State or country) Ind.

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Robt. Madden (Address) 528 Dolphin St.

18. BURIAL, CREMATION, OR REMOVAL Place St. Andrew Date 11-10-43

19. UNDERTAKER Geo. Y. Nelson (Address) 1303 Presbury St.

20. NOV 9 - 1943 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 6 - 1943

22. I HEREBY CERTIFY, That I attended deceased from Oct 17 - 1943 to Nov 6 - 1943

I last saw him alive on Nov 4 - 1943 Death is said to have occurred on the date stated above, at 230 P. m.

The principal cause of death and related causes of importance were as follows: Diabetes mellitus (coma) Date of onset indef. 4 days

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Glucose Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no If so, specify _____

(Signed) Chas. J. Keller M. D.

(Address) 722 W. Monumental

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 09959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A

(e) Length of stay in Baltimore (yrs., mo., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. 713 N. Eden St
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years Months Days If less than one day
25 6 4 hr. min.9. Birthplace Irma, S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Ira Monte13. Birthplace S.C.14. Maiden Name Ella Potlocks15. Birthplace S.C.16 (a) Informant Ella Monte(b) Address Box 59 - Route 1 - Columbia, S.C.17 (a) Burial (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Columbia, S.C.18 (a) Funeral director Elynn Wilson(b) Address 1000 Brantley Ave19 (a) Huntington Williams

NOV 9 - 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1943, at 4:55 M21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions Pregnancy at this time

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury November 3, 1943 4:45 M(b) Where did injury occur? 713 N. Eden St(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No(d) Means of injury Shot23. Signature Robert L. Graham M.D.Date signed Nov. 4, 1943 Medical Examiner

G 09970

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09970

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2020 Kennedy Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) - 9 - 8

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

3 (a) FULL NAME

William Johnson

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 52 Months 2 Days 42 hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Pleasure

11. Industry or business News Reporter

12. Name William A. Johnson

13. Birthplace Baltimore

14. Maiden Name Mary George

15. Birthplace Indiana

16 (a) Informant Mrs. J. Johnson

(b) Address 2020 Kennedy Ave

17 (a) Burial (b) Date thereof 11 11 1943

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location

18 (a) Funeral director Mary M. Wiedfeld

(b) Address 521 E. 122 St

19 (a) (b)

(Date rec'd by registrar) Huntington Williams

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2020 Kennedy Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1943 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1943 to Nov. 7 1943, and that I last saw him alive on Nov. 7 1943.

Immediate cause of death

Hypertensive cardiovascular disease

Due to

Due to

Other Conditions Acute cardiac

failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature W. H. Sprenger

Address 1402 B. Larnale Date signed 11-9-43

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 9 - 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 09971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09971
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Antone Joaquin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21st 1911

8. AGE: Years Months Days If less than one day
32 9 17 hr. min.

9. Birthplace New Bedford Mass
(Town, county, and state)

10. Usual Occupation Stewart Mats & Blinds

11. Industry or business

12. Name Antone Joaquin

13. Birthplace St Michael Azores

14. Maiden Name Rose Sylva

15. Birthplace St Michael Azores

16 (a) Informant Antone Joaquin

(b) Address New Bedford Mass

17 (a) Burial (b) Date thereof Nov 9th 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location New Bedford Mass

18 (a) Funeral director Leo S. Cook

(b) Address 1701-03 N. Park Park Ave

Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Mass. (b) County

(c) City or town Baltimore Near Bedford
(If outside city or town limits, write RURAL and give town)

(d) Street No. 24 Emma St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-1943 at 10:05 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-6-43 at 7:15 P M

(b) Where did injury occur? Auto. St. near Hanover St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Person struck by street car

23. Signature Thomas J. Waldeis M.D.

Date signed 11-9-43 Medical Examiner.

NOV 10 1943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09972
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 729 W CROSS ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 729 W CROSS ST.
(If rural give location)

(e) Citizen of foreign country (Yes or No)
If yes, name country.

3 (a) FULL NAME

DAVIDSON H HADEL

3 (b) If veteran, name war

3 (c) Social Security Account
No. —

4. Sex

MALE WHITE

5. Color or race

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANNIE E. HADEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 28-1869

8. AGE: Years 74 Months 2 Days 9
If less than one day hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business SWINDLE GLASS &

12. Name WILLIAM HADEL

13. Birthplace BALTO. MD.

14. Maiden Name NOT KNOWN.

15. Birthplace

16 (a) Informant ANNIE E. HADEL

(b) Address 729 W CROSS ST.

17 (a) BURIAL (b) Date thereof NOV-11-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory GLAN HAVEN
Location GREEN BURIAL MD

18 (a) Funeral director Bernard C. Harbo

(b) Address 121 E. 2nd St.
Huntington, W. Va.

19 1-10-1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 7 1943 at 11:00 A

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1938 to 11-7 1943 and that I last saw him alive on 11/7 1943

Immediate cause of death

Due to Broncho Pneumonia
Due to Left Hemiplegia
Due to Generalized Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph H. Lawkatis

Address 679 Washington Blvd. signed 11/7/43

Duration

249

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09973

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wm. H

(c) Hospital or institution:

33rd St.(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind.(b) County Balto(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2817 Guilford Ave

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Robert Bernard Haynie

3 (b) If veteran, name war

WW

3 (c) Social Security Account

No. 11113

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1889

8. AGE: Years Months Days If less than one day

541-17

hr.

min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation Automobile Business

11. Industry or business

FATHER

12. Name Robert B. Haynie13. Birthplace Va.

MOTHER

14. Maiden Name Mittie E. Shipley15. Birthplace Va.16 (a) Informant Mrs. David C. Erb Daughter(b) Address 2817 Guilford Ave City17 (a) Burial (b) Date thereof 11/11/43

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory LorraineLocation Balto Co. Md.18 (a) Funeral director William Cook Inc(b) Address 1217 St. Paul St

NOV 10 1943

(Date rec'd by registrar) Huntington Williams

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1943, at 10 300 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1943, to Nov 8 1943, and that I last saw him alive on Nov 8, 1943.

Immediate cause of death

Cardio Respiratory Failure

Duration

Due to Cerebral Hemorrhage 15 daysDue to Arteriosclerotic Hypertension ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James N. McCosh Jr.Address Union Memorial Hospital Date signed 4-8-43

M. D.

09974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09974

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

(b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-43 19 at 6:40 P.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30-42 19 to 11-8-43 19, and that I last saw him alive on 11-8-43 19.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09976

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1302 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

3 (a) FULL NAME

Hattie Johnson

3 (b) If veteran, name war

None

3 (c) Social Security Account

No. None

4. Sex

F

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October, 1872

8. AGE:

Years

Months

Days

If less than one day

71

1

hr.

min.

9. Birthplace Hartford, Co. Md

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
MOTHER

12. Name Steven Johnson

13. Birthplace Hartford, Co. Md.

14. Maiden Name Sarah Jane Young

15. Birthplace Hartford, Co. Md.

16 (a) Informant Everett Johnson (Son)

(b) Address 1302 McCulloh St.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 11/10/1943

(month) (day) (year)

(c) Cemetery or crematory

St. Ambrose
Balts. Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton, Ave

NOV 10 1943

(Date rec'd by registrar)

Huntington Williams
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1302 McCulloh St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/1943 19 43 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1943 to 11/7 1943, and that I last saw her alive on 11/7 1943.

Immediate cause of death

Cardio - Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

6 mos

3 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

B. J. Hatcher

Address 12 N. The Ave

Date signed 11/19/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09977

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address *Layeth • Pulaski*
(c) Hospital or institution *Bon Secours*
(d) Length of stay in hospital or inst. (yrs., mos., or days) *6*
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md* (b) County
(c) City or town *Balto*
(If outside city or town limits, write RURAL and give town)
(d) Street No. *426 N Lakewood Ave*
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Catherine C Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced *married*

6 (b) Name of husband or wife *Charles L Collins*
6 (c) If alive, give age *79* years

7. Birth date of deceased (mo., day, yr.) *Mar 12/1864*

8. AGE: Years *79* Months *7* Days *27* If less than one day hr. min.

9. Birthplace *Balto Md*
(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

FATHER 12. Name *Jacob Seidel*

13. Birthplace *Germany*

MOTHER 14. Maiden Name *Dora Knopf*

15. Birthplace

16 (a) Informant *Charles L Collins*

(b) Address *426 N Lakewood Ave*

17 (a) *Bural* (b) Date thereof *Nov 12/43*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *MT Carmel*

Location *O'Donnell St Balto*

18 (a) Funeral director *William Funeral Home*

(b) Address *2008 Orleans St*

NOV 10 1943 (b) *Huntington Williams, Md*

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/9* 19*43* at *1 A M*

21. I certify that death occurred on the date above stated; that I attended deceased from *11/4* 19*43*, to *11/9* 19*43*, and that I last saw her alive on *11/9* 19*43*.

Immediate cause of death *Congestive Heart Failure*

Due to *Arteriosclerotic Cardiovascular Disease*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *G. Seymour Royer* Address *Bon Secours Hosp* Date signed *11/9/43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09978
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country.

3 (a) FULL NAME

MR. DALLAS M. MANLOVE.

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 8

1943, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1943 to Nov 9 1943, and that I last saw him alive on Nov 9 1943.

Immediate cause of death EMACIATION
& DEHYDRATION - ASCITES

Due to CARCINOMATOSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: ✓

of autopsy: CARCINOMATOSIS

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

E. N. Stewart Jr

Address

Baltimore Hosp

Date signed 11/9/43

NOV 10 1943

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09979
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address **Wyman Park Drive & 51st St.**
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) **10 days**
(e) Length of stay in Baltimore (yrs., mos., or days) **16 yrs.**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Md.** (b) County **Baltimore**
(c) City or town **Catonsville**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **214 Bloomsbury Ave.**
(If rural give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3 (a) FULL NAME **THOS. NILS BASIL BOWERS**

- 3 (b) If veteran, name war **World's War** 3 (c) Social Security Account No. **-**

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**

- 6 (b) Name of husband or wife **Lucille White** 6 (c) If alive, give age **40** years

7. Birth date of deceased (mo., day, yr.) **July 29, 1895**

8. AGE: Years **48** Months **3** Days **10** If less than one day **9** hr. min.

9. Birthplace **San Antonio, Texas**
(Town, county, and state)

10. Usual Occupation **Ins. Agt. 9/29/43**

11. Industry or business

12. Name **Alex Bowers**
13. Birthplace **England**

14. Maiden Name **Svea Kindlund**
15. Birthplace **Sweden**

- 16 (a) Informant **Records, U.S. Marine Hospital**
(b) Address **Baltimore, Md.**

- 17 (a) **Funeral** (b) Date thereof **11-13-43**
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematorium **Baltimore**
Location **Walden**

- 18 (a) Funeral director **W. A. Furley**
(b) Address **Fulton Ave. Baltimore**
(Date rec'd by registrar) **Nov 10 1943**

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH **Nov. 8, 1943** at **6:30** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 29, 1943** to **Nov. 8, 1943**, and that I last saw him alive on **Nov. 8, 1943**.

Immediate cause of death **Brain tumor, Lat. Ventricle Left Cerebral hemisphere**

Duration
Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation **None**

Major findings of operations

of autopsy **As above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide **No**
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

Address **Baltimore, Md.**Date signed **11/9/43**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09980
Registered No.

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Howard + Madison*
- (c) Hospital or institution: *Maryland General Hospital*
- (d) Length of stay in hospital or inst. (~~year~~, or days) *1 1/2*
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md* (b) County *Anne Arundell*
- (c) City or town *Glen Burnie*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *Delmar Av.*
(If rural give location)
- (e) Citizen of foreign country? *No* (Yes or No)
If yes, name country

3 (a) FULL NAME

Thomas C. Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

*W*6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3-1-1878*

8. AGE: Years *65* Months *6* Days *7* If less than one day
65 *64* *8* *7* hr. min.

9. Birthplace *Maryland*
(Town, county, and state)10. Usual Occupation *Retired*

11. Industry or business

12. Name *Thomas H. Murray*13. Birthplace *Md.*14. Maiden Name *Julia E. Murray*15. Birthplace *Md.*16 (a) Informant *Hugh P. Pearson*

(b) Address

17 (a) *Burial* (b) Date thereof *11-12-43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Cathedral*
Location *East Md.*18 (a) Funeral director *Funeral Home*(b) Address *Fulton Ave. & Gay St.*19 (a) *NOV 10 1943* (b) *Huntington Williams*
(Date read by registrar) (Registrar)

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 8* 19*43*, at *5:45 P*

21. I certify that death occurred on the date above stated; that I attended deceased from *Nov. 7* 19*43*, to *Nov. 8* 19*43*, and that I last saw him alive on *Nov. 8* 19*43*.

Immediate cause of death

Rheumatic heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature *Herman Williams* M. D.Address *Md. Gen. Hosp.* Date signed *Nov 8, 1943*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

09931
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

St. Joseph's Hospital 10 days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town, limit to RURAL and give town)

(d) Street No. 926 E. Biddle St (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Mrs. Florence Eppler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year)

Mar 20 1882

8. AGE:

Years

Months

Days

If less than one day

67

7

19

hr

min.

9. Birthplace

Maryland

10. Usual Occupation

11. Industry or business

None

MOTHER FATHER

12. Name

James Denny

13. Birthplace

Maryland

14. Maiden Name

Martha Durham

15. Birthplace

Maryland

16 (a) Informant

(b) Address

Next door

17 (a)

(b) Date thereof

11-11-43

(c) Cemetery or crematorium

(d) Location

Catholic

Baltimore

18 (a) Funeral director

(b) Address

Funeral Home

1000 N. Broadway

NOV 10 1943

(Date rec'd by registrar)

(b) Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1943 at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1943 to Nov. 8 1943 and that I last saw him alive on Nov. 8 1943.

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Lusting

Address H. Joseph's Hosp. Date signed 11-18-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09982

POSTER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09982
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1659 Dickey Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 138-09-5493

4. Sex

5. Color or race

6 (a) Single, married, widowed or divorced

6 (b) Name of husband or wife Mary Magdalene Doster6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace Burlington, Burlington, New Jersey

(Town, county, and state)

10. Usual Occupation Printer11. Industry or business Label Printing12. Name John Traugott Doster13. Birthplace Allentown Penna.14. Maiden Name Exelmer Applegate15. Birthplace New Jersey16 (a) Informant Howard E. Doster(b) Address 4210 Cottman Ave.17 (a) Burial (b) Date thereof Nov 11-49

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location

18 (a) Funeral director George Schilling(b) Address 3624 Quince Orchard RdHuntington Williams, Md

(Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/43 1943, at 7:45 PM21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Nov 8 1943.And that I last saw him alive on Nov 6 1943.

Immediate cause of death

Due to respiratory failureDue to metastatic brain tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John Traugott DosterAddress Univ. HospitalDate signed 11/8/43

M. D.

09983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09983

Registered No.

956

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Howard + Madison*
- (c) Hospital or institution: *Ms. Gen. Hosp*
- (d) Length of stay in hospital or inst. (months, or days) *16*
- (e) Length of stay in Baltimore (yrs., mos., or days) *?*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MD* (b) County *5*
- (c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *1145 N. Bentalon*
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME *Ms. Charlotte M. McCoubrey*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *5/15/1895*8. AGE: Years Months Days If less than one day
48 5 22 hr. min.9. Birthplace *Ms. (Balto.)*
(Town, county, and state)10. Usual Occupation *H. W.*

11. Industry or business

12. Name *Charles Baguoe*13. Birthplace *New York*14. Maiden Name *Sophie Walther*15. Birthplace *Baltimore*16 (a) Informant *Mr. Albert H. McCoubrey*(b) Address *1145 N. Bentalon St.*17 (a) *Burial* (b) Date thereof *11/11/43*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *Govan's Presby.*
Location *Govan's, Balto. Md.*18 (a) Funeral director *Thos. J. Dickner & Sons*19 (a) *10 1943* (b) *Balto. Md.*

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 7* 19*43*, at *8:30 P*21. I certify that death occurred on the date above stated; that I attended deceased from *10-22* 19*43*, to *11-7* 19*43*, and that I last saw her alive on *11-7-43* 19

Immediate cause of death

Rheumatic heart disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: *Rheumatic H.D.*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature *L. Herman Williams*Address *Ms. Gen. Hosp* Date signed *M. D.*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Nov. 7, 1943

Age is especially important. Physicians: please write the causes of death clearly and legibly.

09984

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 E. 41st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. 41st St.
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY TAYLOR CHINN
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Kate Taplin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 17, 1850
8. AGE: Years 93 Months 8 Days 21 If less than one day hr. min.
9. Birthplace Birmingham, England
(Town, county, and state)
10. Usual Occupation Retired Silversmith
11. Industry or business
12. Name Thomas Chinn
13. Birthplace England
14. Maiden Name Mary A. Smith
15. Birthplace England
16 (a) Informant Mr. Leonard Chinn
(b) Address 510 E. 41st St.
17 (a) Burial (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
Balto., Md.
19 (a) Date rec'd by registrar 10-10-1943 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1943, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Nov 8 1943 and that I last saw him alive on Nov 7 1943.
Immediate cause of death Coronary Artery Disease
Due to Infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) County (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. J. Tickner
Address W. J. Tickner & Sons Date signed 11-10-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 156

G 09985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

G 09985

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

William E. Ricketts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Nannie Ricketts

6 (c) If alive, give age

39 years

7. Birth date of deceased (mo., day, yr.)

4-4-99

8. AGE:

Years

Months

Days

If less than one day

44

7

5

hr.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual Occupation

Sheet Metal Worker

11. Industry or business

Virginia Navy Yard

FATHER
MOTHER

12. Name

James Ricketts

13. Birthplace

Virginia

14. Maiden Name

Elizabeth Borum

15. Birthplace

Virginia

16 (a) Informant

Records

(b) Address

JOHNS HOPKINS HOSPITAL

17 (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

11/10/43

(c) Cemetery or crematory

Location

Portsmouth, Va.

18 (a) Funeral director

WM. J. TICKNER & SONS

(b) Address

Balto., Md.

NOV 10 1943

(b) Registrar

VB 154

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 9 1943 at 5:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1943 to Nov. 9 1943. and that I last saw him alive on Nov. 9 1943.

Immediate cause of death

Metastatic cancer
to pleural effusion

Due to

Carcinoma of urinary
Bladder.

Due to

Other Conditions

(Include pregnancy within 6 months of death)

Date of operation

2 wks ago

Major findings of operation:

Same

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(e) Means of injury

23. Signature

Address

Date signed

Duration

2 mo?

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

G 09986

JL -84734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G 09986

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1021 N. Calvert St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

Ruth Dudley

3 (b) If veteran, name war

3 (c) Social Security Account

No. ?

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife David (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1875

8. AGE: Years

Months

Days

If less than one day

68

5

11

hr.

min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name John Henderson

13. Birthplace Va.

MOTHER

14. Maiden Name Maria Chaney

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address

4940 Eastern Ave.

17 (a) Removal

(b) Date thereof 11/10/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Petersburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address

Baltimore, Md.

NOV 20 1943

Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/43 19 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/1943 to 11/9/1943, and that I last saw him alive on 11/9/1943.

Immediate cause of death

BILATERAL PULMONARY TUBERCULOSIS

Duration

5 YEARS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

Ruth Mattman

Address

B. C. H.

Date signed

M. D.

11/9/43

09987

BALTIMORE CITY HEALTH DEPARTMENT

G 09987

CERTIFICATE OF DEATH

Registered No.

104a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

1219 E. North.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

Edward J. Moran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 14-43

8. AGE:

Years

Months

Days

If less than one day

1

2120

hr.

min.

9. Birthplace

Balt.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

Edward J. Moran

13. Birthplace

Baltimore

MOTHER

14. Maiden Name

Hedeyes Fitz

15. Birthplace

Baltimore

16 (a) Informant

Hedeyes Moran

(b) Address

1219 E. North. Ave.

17 (a)

Burial

(b) Date thereof

Nov. 11-43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

St. Peter's Cem.

Location

Riggs Ave.

18 (a) Funeral director

John R. Morgan

(b) Address

3000 E. Balt. H.

NOV 10 1943

(b) Huntington Williams, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

1219 E. North Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 9 1943 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Nov. 9 1943, and that I last saw him alive on Nov 6 1943.

Immediate cause of death

Upper Respiratory Infection

Duration

1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

James L. [Signature]

Address

1219 E. North

Date signed 11/9/43

Approved by Howard J. [Signature] M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09988
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 10 1943

Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/8

1943.

at 5⁴⁸ P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1942 to Nov 8 1943 and that I last saw him alive on 11/6 1943.

Immediate cause of death

Bronchopneumonia

Duration

3 days

Due to

Due to

Other Conditions

Arteriosclerotic C.V. Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Karl L. Hoffman

Address 1212 N. Patterson

Date signed 11/9/43

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 09989

AB-83410

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4940 Eastern Ave.
- (c) Hospital or institution:
Baltimore City Hospitals 2 mos. 15 days
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 523 Turfbridge Road
TURFBRIDGE (If outside city or town limits, write RURAL and give town)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Ella Plowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-18528. AGE: Years 91 Months 2 Days 7 6 If less than one day hr. min.9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

12. Name Horace Warthen13. Birthplace Md.14. Maiden Name Augusta Morrison15. Birthplace Md.16 (a) Informant Baltimore City Hospitals(b) Address Records17 (a) Burial (b) Date thereof Nov. 11-43
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. Elizabeth
Location Frederick Rd.18 (a) Funeral director John A. Johnson(b) Address 3000 E. Baltimore St.19 NOV 10 1943 Huntington Williams, M.D. Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1943 at 7 9 M21. I certify that death occurred on the date above stated; that I attended deceased from 8:23 1943 to 11-7 1943 and that I last saw him alive on 11-7 1943

Immediate cause of death

Arteriosclerotic C. V. Disease
Cardiac Decompensation

Duration

12 hrs.

Due to

Due to

Other Conditions

Interlobar pneumonia
Fracture of femur
(Include pregnancy within 3 months of death)Date of operation 8-26-43Major findings of operation: Same

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide Unlikely to give
- (b) Date of occurrence August 23, 1943 M
- (c) Where did injury occur? Baltimore, Maryland
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
- (e) Means of injury Fracture of femur

23. Signature Donald R. Webb M.D.Address Baltimore City Date signed 11-8-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PRINTED, WITH NO SPACING INK. EVERY ITEM OF INFORMATION IS ESSENTIAL. PHYSICIANS: PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY. CORRECT AGE IS ESPECIALLY IMPORTANT.

Approved for H. H. Wollenschen M.D.

Robert Lee Graham M.D.

09991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09991
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address **Wyman Park Drive & 31st St.**

(c) Hospital or institution:

U. S. Marine Hospital(d) Length of stay in hospital or inst. (yrs., mos., or days) **14 days**(e) Length of stay in Baltimore (yrs., mos., or days) **Since 1892**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.** (b) County(c) City or town **Baltimore**

(If outside city or town limits, write RURAL and give town)

(d) Street No. **820 S. Highland Ave.**

(If rural give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

3 (a) FULL NAME **JOHN LOUIE BRUTSCHER**3 (b) If veteran, name war
Sp. American3 (c) Social Security Account
No. **NONE**4. Sex
Male5. Color or race
White6 (a) Single, married, widowed, or divorced.
Married6 (b) Name of husband or wife **Francis Thanner**6 (c) If alive, give age **69** years7. Birth date of deceased (mo., day, yr.) **May 6, 1874**8. AGE: Years Months Days If less than one day
69 4 6 3 hr. min.9. Birthplace **Germany**
(Town, county, and state)10. Usual Occupation **None**11. Industry or business **-**FATHER 12. Name **Jacob Brutscher**13. Birthplace **Germany**MOTHER 14. Maiden Name **Theresa ?**15. Birthplace **Germany**16 (a) Informant **Records, U.S. Marine Hospital**(b) Address **Baltimore, Md.**17 (a) **BURIAL** (b) Date thereof **NOV. 13/4**
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory **US. NATIONAL**
Location **FREDERICK AVE.**18 (a) Funeral director **Lilly and Guler, INC.**(b) Address **403 S. WOLFE ST.****NOV 10 1943** (b) **Huntington Williams, M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH **November 9, 1943** at **1:00 PM**21. I certify that death occurred on the date above stated; that I attended deceased from **Oct. 26, 1943** to **Nov. 9, 1943**, and that I last saw him alive on **Nov. 9, 1943**.Immediate cause of death **Acute thrombosis of left pulmonary artery**Duration
1 dayDue to **Coronary heart disease with old occlusions of both**
known right & left coronary arteries.

Unk.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation **None**

Major findings of operation:

of autopsy: **As above**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide **No**(b) Date of occurrence at **M**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? **While at work?**
(Specify type of place)

(e) Means of injury

23. Signature

Address **Baltimore, Md.**Date signed **11/9/43**

Va-13903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09992
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 2926 Hudson Street
(c) Hospital or institution: -

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Hudson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

JOHN KIGGINS

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 9 1882

8. AGE: Years Months Days If less than one day
60 11 28 hr. min.

9. Birthplace BALTIMORE MD.

(Town, county, and state)

10. Usual Occupation

LABORER

11. Industry or business

12. Name THOMAS KIGGINS

13. Birthplace BALTO. MD.

14. Maiden Name ELIZABETH ONEILL

15. Birthplace MD.

16 (a) Informant MARY LANAHAN (SISTER)

(b) Address 2926 HUDSON ST.

17 (a) BURIAL (b) Date thereof NOV. 11/43

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory PARK WOOD

Location TAYLOR AVE.

18 (a) Funeral director Lilly and Zeller, INC.

(b) Address 403 S. WOLFE ST.

NOV 10 1943 Date rec'd by Registrar Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION 7 P.

20. DATE OF DEATH 11-7-43 1943, at M

21. I certify that I took charge of the remains described above, held an inquiry thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wollenweber M.D.

Date signed 11-8-43 Medical Examiner.

09993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09993

Registered No. _____

1. PLACE OF DEATH:

Baltimore City, Maryland

(a) Street address 3603 FOSTER AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 46 Y RS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)(d) Street No. 3603 FOSTER AVE.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
• If yes, name country

3 (a) FULL NAME

HELEN A. DOBRY

3 (b) If veteran, name war

NO

3 (c) Social Security Account

No. NONE

4. Sex

FEMALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife CHARLES T. DOBRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 29 1886

8. AGE: Years Months Days If less than one day
57 7 10 9 hr. min.

9. Birthplace GERMANY

(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name JOHN HARTMANN

13. Birthplace GERMANY

14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant CHARLES T. DOBRY (HUS.)

(b) Address 3603 FOSTER AVE.

17 (a) BURIAL (b) Date thereof NOV. 12/4 3
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Gentler INC.

(b) Address 403 S. WOLFE ST.

NOV 10 1943 (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH NOV. 8 19 43 at 6/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Nov 8 1943, and that I last saw him alive on Nov 8 1943.

Immediate cause of death

Arterio-sclerosis
Hypertension
Due to Cerebral Hemorrhage
Nov 3 - 1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles E. Williams M. D.

Address 3505 Foster Ave. Date signed 11/9/43

Duration

1939
1943

1943

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G 09994
Registered No.

13B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Howard Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

801 Druid Hill Ave.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

James Auld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1898

8. AGE: Years

Months

Days

If less than one day

44 45

11

14

hr.

min.

9. Birthplace

Greenwood, South Carolina

(Town, county, and state)

10. Usual Occupation

Paperhanger

11. Industry or business

FATHER

12. Name

William Auld

13. Birthplace

South Carolina

MOTHER

14. Maiden Name

Miss Gilliam

15. Birthplace

16 (a) Informant

Mrs. John Lewis

(b) Address

913 N. Arlington Ave.

17 (a)

Burial

(b) Date thereof

Nov. 12, 1943

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Calvary

Location

18 (a) Funeral director

A. H. Hester

(b) Address

913 N. Arlington Ave.

NOV 10 1943

(Date rec'd by Registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 8

1943, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1943, to Nov. 8, 1943, and that I last saw him alive on Nov. 8, 1943.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other Conditions

Myocardial Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. B. B. B.

Address

Howard Hospital

Date signed 11/5/43

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

444040
9995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09995
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1501 N. Eden St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Julie Cannon

3 (b) If veteran, name

3 (c) Social Security Account
No.

4. Sex

Female

5. Color or race

Black

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-41

8. AGE: Years Months Days If less than one day
1 23¹⁰ 26 hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation

Child

11. Industry or business

FATHER
MOTHER

12. Name Samuel Cannon

13. Birthplace Md

14. Maiden Name Johnson

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 10, 1943
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

Nov. 10, 1943 (b) Thurston Williams, M.D.
(Date of death) (Signature of Registrar)

VS 140

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1943 at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4, 1943 to Nov. 8, 1943, and that I last saw him alive on Nov 8, 1943.

Immediate cause of death

Respiratory Failure

Due to Tuberculosis
Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John W. Chambers

Address Johns Hopkins Hospital signed 11/2/43

Duration

3 1/2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK: Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4040 Eastern Ave.

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 26 YRS.

3 (a) FULL NAME

Nicholas, Goncharuk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 8, 1900

8. AGE: Years Months Days

52

10

26

If less than one day

hr.

min.

9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation

Tailor

11. Industry or business

FATHER

12. Name Paul Goncharuk

13. Birthplace Russia

MOTHER

14. Maiden Name Marx, Ignatuk

15. Birthplace Russia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Nov. 10 1943

(Burial, cremation, or removal)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

NOV 10 1943

VS 150

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

MJ-34676

Registered No.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 134 S. Eaton St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1943 at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1943 to 11/4 1943 and that I last saw him alive on 11/4 1943.

Immediate cause of death

acute cardiac failure
Due to A.S.H. C.V.D.
2 marked decomposition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

E. L. Sigman
BCH Date signed 11/6

Duration

5-6 d.

1 yr.

PHYSICIAN

Underline the cause to which death should be charged directly.

08997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09997

Registered No.

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:

(a) Baltimore City, Maryland
(b) Street address 1653 Harford Avenue
(c) Hospital or institution:(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME

Annie L. Heinstadt

3 (b) If veteran, name war
None3 (c) Social Security Account
No. None4. Sex
Female5. Color or race
White6 (a) Single, married, widowed, or
divorced. Married

6 (b) Name of husband or wife John F. Heinstadt

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 25th, 1880

8. AGE: Years 63 Months 0 Days 15 14 If less than one day
min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name John Woods

13. Birthplace Baltimore Md.

14. Maiden Name Eleanor Carter

15. Birthplace Baltimore Md.

16 (a) Informant Mr. John F. Heinstadt (Husband)

(b) Address 1653 Harford Avenue

17 (a) Burial (b) Date thereof Nov. 13, 1942
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

NOV 10 1943 Huntington Williams, M.D.
Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1942 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attend-
ed deceased from Oct. 1938 to Oct. 1942
and that I last saw him alive on Oct 25, 1942

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public
place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Quinn

Address 1761 E Natl. R. Date signed 11/10/42

Duration

PHYSICIAN

Underline the
cause to which
death should be
charged statis-
tically.

09998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHG 09998
Registered No.

1. PLACE OF DEATH:

Baltimore City, Maryland
(b) Street Address 1115 N. Gay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

RAYMOND MONFORD

3 (b) If veteran, name war

3 (c) Social Security Account
No.4. Sex
Male5. Color or race
Colored6 (a) Single, married, widowed, or
divorced. **Single**

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 17 Months Days If less than one day
hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Nathaniel Monford13. Birthplace Va.14. Maiden Name Maggie Pinkney15. Birthplace Va.16 (a) Informant Maggie Monford(b) Address 1115 N. Gay St.

17 (a) Burial (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson(b) Address 1000 Brantley Avenue

NOV 10 1943 (b) Huntington Williams, M.D.
(Registered by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 - 1943, at 8:10 A.M.

21. I certify that I took charge of the remains described above, held an
Autopsy - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came
to his death on the day stated above, and death in my
opinion resulted from: natural causes ☒ accident ☐ suicide ☐
homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Rheumatic Carditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
place? While at work?

(d) Means of injury

23. Signature Hugh M. Hally M.D.

Date signed

For H. M. Hally, M.D. by H. M. Hally, M.D.

PLEASE WRITE IN INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

09999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 09999

Registered No.

83a

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore, Md.

(c) Hospital or institution:

Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1226 McCulloh St.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

3 (a) FULL NAME

LEROY CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

1895

8. AGE: Years Months Days

48

If less than one day

hr.

min.

9. Birthplace

Amelia Co., Va.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

George Carter

13. Birthplace

Amelia Co., Va.

MOTHER

14. Maiden Name

Antoinette Hastings

15. Birthplace

Amelia Co., Va.

16 (a) Informant

Marie Montague

(b) Address

727 N. 2nd Richmond, Va.

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

11/10/43

(month) (day) (year)

(c) Cemetery or crematory

Location

Richmond, Va.

18 (a) Funeral director

James B. Hayes

(b) Address

142 W. Hill St.

(a)

10 1943

(Date rec'd by registrar)

Huntington Williams, M.D.

Registrar

MEDICAL CERTIFICATION

7:50 A.

20. DATE OF DEATH November 5, 1943, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my

opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wallenmeyer M.D.

Date signed 11-5-43 Medical Examiner.

PLEASE WRITE CLEARLY - Physicians: please write the causes of death clearly and legibly. correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10000

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 10000
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky (b) County
(c) City or town Mt VERNON
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella J. Laswell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-23

8. AGE: Years 20 Months 2 Days 14-12 hr. min.

9. Birthplace Ky
(Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name JACK LASWELL

13. Birthplace Ky

14. Maiden Name Stella Adams

15. Birthplace Ky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 11/10/43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Vernon
Location Mt Vernon - Kentucky

18 (a) Funeral director Wm Cook Dore

(b) Address 217 St Paul St.

NOV 10 1943 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1943 at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1943 to Nov 9 1943 and that I last saw her alive on Nov 9 1943.

Immediate cause of death Brain abscess

Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Nov 7, 1943
Major findings of operation: Brain abscess
of autopsy: Brain abscess

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hugo V. Ryzak
Address Johns Hopkins Hosp Date signed 11-10-43 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.



CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 7/17 DAY
OF 1963 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH # 06701 AND
ENDING WITH # 10,000 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL